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ABSTRACT

Described as a survival manual for Indian women in medicine, this collected work contains diverse pieces offering inspiration and practical advice for Indian women pursuing or considering careers in medicine. Introductory material includes two legends symbolizing the Medicine or Spirit Woman's role in Indian culture and an overview of Indians Into Medicine (INMED) including the participation of women in the program. Chapter 2 reviews the role of Indian women in history, emphasizing their heritage of equal status and leadership in tribal governments. In Chapter 3 Lois Steele, M.D., writes a personal narrative about the pros and cons of medical school and work as a physician. Chapter 4 presents short biographies of Susan La Flesche-Picotte and Lillie Rosa Minoka Hill, the first American Indian women physicians in the United States. Chapter 5-8 discuss stereotypes that affect Indian women pursuing professional careers, experiences of individuals who have succeeded in medical school, and child rearing concerns of Indian parents leading non-traditional lives. Chapter 9 presents spiritual advice contributed by INMED board member Constance Jackson, and chapter 10 summarizes the accomplishments of several Indian nurses. The final chapter suggests various ways to cope with the stresses of medical school, including discrimination against minorities and women. (JHZ)

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MEDICINE WOMEN

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ABOUT THE COVER

The White Buffalo Calf is depicted on the cover of this book. Details of the legend vary from tribe to tribe as is common of history passed on by word of mouth. The White Buffalo Calf Woman saved the tribes that speak of her, from famine. She also rewarded young men who were virtuous and did not force themselves on a woman.

In modern times, White Buffalo Calf Society is the name of a group at Rosebud Reservation, South Dakota that was formed to combat wife abuse in the community. The men of the community have laughingly told about their Black Angus Society to combat husband abuse. The humor is necessary because the White Buffalo Calf is so sacred. The work of the women of the White Buffalo Calf Society is very commendable. They have worked successfully against a very new social evil.

At each Sun Dance, a young virtuous maiden is chosen to represent the White Buffalo Calf Woman, who is a focal personage during the ceremony. The Sun Dance cannot take place without her presence. If she is hurt, or cannot complete the proscribed days, another representative of the White Buffalo Calf Woman must be chosen.

The White Buffalo Calf symbol was chosen for this book as it is one of the most powerful statements of a Medicine or Spirit Woman's role in the Plains culture. We realize other tribes honor Medicine Women with other stories and ceremonies. The powerful Corn Mother of the Southern Tribes, the Little Turtle of the Eastern Woodlands and others could also have been depicted, but our deadlines would not permit the work necessary to present them to you.

The activity which is the subject of this report was supported by the Department of Education, under the auspices of the Women's Educational Equity Act. However the opinions expressed herein do not necessarily reflect the position of policy of the Department of Education, and no official endorsement by the Department should be inferred.

WEEA grant number G008302832

The legend of White Buffalo Calf Woman

by Art Raymond

One winter, long ago, two Lakota warriors of the Minneconjous were away from their clan, hunting for food for their people. It was the Moon of the Frost on the Tipi (January), and drifted snow hid the deer and the buffalo. The hunters were near despair when suddenly a cloud appeared in the distance. Closer and closer it came, then floated to the ground. The hunters watched in awe as a woman stepped from the cloud, graceful in bearing and dazzling in her beauty.

The first hunter, seeing the woman as a messenger from the Great Spirit, raised his arms and said, "She comes that the People might live!" The second hunter was silent. His thoughts were the unclean thoughts of a man who desires to force himself upon a woman.

The beautiful woman waved a red pipe, appealing to the One Great Spirit—and in an instant he of the unclean thoughts vanished from sight. Turning to the first hunter, she said, "Go to your people. Tell your chief and your council that I would meet with them. I will follow you to camp."

Once at the camp, the woman addressed the council and the chief. "You are my people," she said, "yet you suffer from hunger and cold because you do not follow the way of the Great Spirit. I will give you this pipe and these eagle feathers to remind you of Kan'hi. Kan'hi means to live your lives so that when you are old you will have no regret." She held up the pipe. "This pipe is made from the blood stone of all who gave their lives that you might live. Use it in all ceremonies. The pipe represents life itself. The bowl represents the mighty power of the Great Spirit. The stem stands for your life, both individually and as a people. The cha-sa-sa in the bowl of the pipe represents all that was created by the Great Spirit. The light used to ignite the cha-sa-sa is your effort to grow and to be as the Great Spirit meant you to be.

"When you draw on the pipe, the cha-sa-sa burns and creates the smoke that you expel. This upward trail of smoke is your communication with the Great Spirit. The smoking of the pipe will help you reflect on your relationships with the Great Spirit, with your self, your fellow man, and the world. The Great Spirit exists in each one of you: man, woman, and child. Therefore, no one of you is better than another. Believing this will remove all fear, even fear of death, for death is but another step in your growth and development. Next, because the Great Spirit exists in you, you have individual freedom. When you do bad things, you do so because you have chosen not to live properly in relationship to the four entities: the Great Spirit, your self, others, and the world.

"Third, the Great Spirit created all that is, including you. Whatever you are, whatever talents you may have, are not yours, but of the Great Spirit. and they must be shared, that the people might live. The greatest honor you can do another is to share your talents and possessions. To violate a commitment of a relationship, however, breaks the thread of communication with the Great Spirit. Truth is a part of sharing."

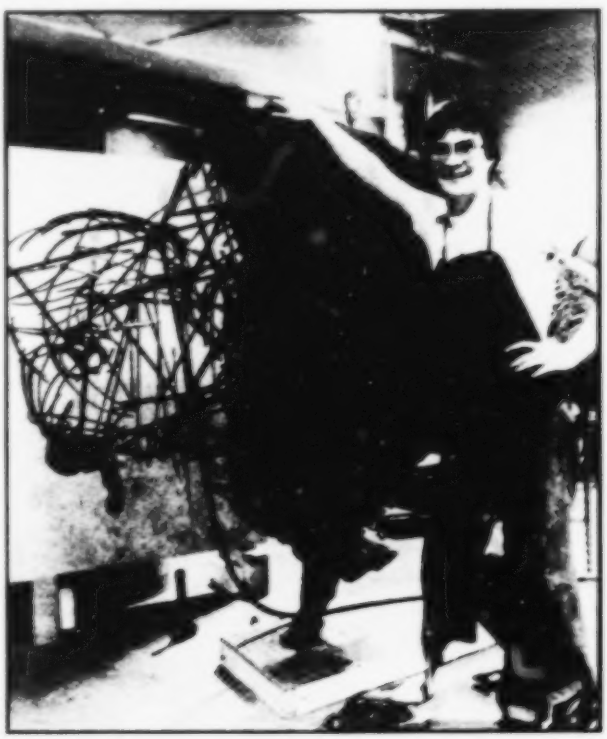
The chief and the council listened as the woman continued to speak: "The Great Spirit, Creator of all that is, exists in all things—in the trees, mountains, grass, and in all things that walk, swim, crawl, and fly. In this sense the Lakota are related to all things of Mother Earth. Therefore, Mother Earth and all she produces must be treated with utmost respect. As with Mother Earth, so it is with the mothers of the people. Woman is the mother of the people and must have an honored and esteemed place among you. When you stop treating your women with respect, the race surely shall die. But with this respect, whatever else happens, the race will live.

"Finally, the Old Ones possess the wisdom of all the ages. They have received the stories of past generations. They have lived a lifetime of experiences. They have given you life. To them you owe your all. Listen to them, and the race will live."

The Woman of the Clouds walked slowly and majestically from the camp out to the plain. There she disappeared without a sign, and in her place stood a white, female buffalo calf. The calf circled the camp four times and disappeared into the clouds. Afterwards, the Lakota, of the Minneconjous Council Fire, discovered that the White Buffalo Calf Woman had left with them the sacred pipe and other paraphernalia.

The year was 1542. The Minneconjous still have the sacred bundle from White Buffalo Calf Woman, and it is passed from generation to generation among the Minneconjous on the Cheyenne River Reservation in South Dakota. And all Lakota believe and know and practice the teachings of White Buffalo Calf Woman in order that the people shall live.

Art Raymond is Director of Indian Program Development at the University of North Dakota.



Ben Brien working on his buffalo, constructed of thin iron bars, in the Visual Arts Department studio, University of North Dakota, 1984. Photo by Mark Best, Grand Forks.

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March 1985, Vol. 8, No. 6, with permission

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MEDICINE WOMEN

Lois Steele, M.D., Director of INMED Program

With Additional material by

Phyllis Old Dog Cross
Connie Jackson
Nancy Lindgren
Juanita Helphrey
Roberta Ferron
Twila Martin-Kekahbah
James Claymore
and other Indian women

Art Work

Bennett Brien

Edited by

Jim Beiswenger
Holly Jeanotte

Typed by

Holly Jeanotte
Vickie J. Meenk

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DEDICATION

This book is dedicated to Phyllis Old Dog Cross, a modern Indian women of medicine and to Twila Martin Kekahbah, who originally conceived the idea of Wein Was'te.

Phyllis shown above with one of INMED's early graduates, Ed Chappabitty, M.D., at an Advisory Board Meeting.

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Phyllis Old Dog Cross is a member of the Mandan and Hidatsa tribes. She is a Psychiatric Nurse Clinician at Rapid City Public Health Service Hospital. Phyllis has been a charter member of the INMED Advisory Board since its inception in 1972. She is a former staff member of the President's Advisory Commission on Mental Health. Her professional experience ranges from United States Air Force Nurse Corps to Director of Psychiatric Nursing for the University of Colorado School of Medicine. In 1982, she received the "Wonder Woman Award". This honor is a reflection of her achievements for women. She has worked to provide scholarship help for INMED students. She has lead workshops on coping with stress and handling identity problems for the women at the University of North Dakota.

Twila Martin Kekahbah is a member of the Turtle Mountain Chippewa Tribe of North Dakota. She was the first American Indian appointed to the Phelps Stokes Foundation Board of Trustees, and also the first American Indian VISTA worker. She is a former program developer at Baker University and Haskell Indian Junior College. She presently has a financial award from the Kellogg Foundation to pursue her interests in economic development on the Turtle Mountain Reservation. Twila has dedicated her time and effort for educational equity, women issues, and her people. She also has been a Charter Member of the INMED Advisory Board since its inception in 1972.

These two women have given unselfishly of their own time and money to enable other Indian women to have an opportunity to pursue medical careers.

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FOR FURTHER INFORMATION WRITE OR CALL:

INMED - SCHOOL OF MEDICINE
501 North Columbia Road
Grand Forks, North Dakota 58201
(701) 777-3037, 3467

Artwork for this publication was done by Bennett Brien. Ben is an enrolled member of the Turtle Mountain Chippewa Tribe of North Dakota. He has attended the American Indian Art Institute in New Mexico, and holds a Bachelor of Fine Arts degree from the University of North Dakota. Ben's experience includes designing logos for radio stations and his works have appeared in North Country, Drawings In Metchif Dictionary, and other publications. Ben is a well-known area artist and sculptor.

The activity which is the subject of this report was supported by the Department of Education, under the auspices of the Women's Educational Equity Act. However the opinions expressed herein do not necessarily reflect the position of policy of the Department of Education, and no official endorsement by the Department should be inferred.

CHAPTER 1

INDIANS INTO MEDICINE

INMED

He who has health has hope;
He who has hope has everything. (Old Proverb)

The INMED symbol:

was developed by Dr. Lionel deMontigny, a Turtle Mountain Chippewa, and another Chippewa artist, Albert J. "Chip" Houle, in about 1973. Dr. deMontigny was the first Indian physician to graduate from the University of North Dakota prior to the inception of the Indians Into Medicine (INMED) Program.

Eastern Woodland Indians believe the world was created when a woman fell from the sky to the endless sheet of water below. Two swans saved her from drowning and took her to the Great Turtle, master of all animals. He called a council to figure out how to bring earth up to make an island for the woman. Many animals tried, but died in the attempt. Old Lady Toad finally dove down and brought some earth up to the Turtle. She put it on his back, and then died from exhaustion. The Turtle then supported the earth on his back as it grew into the island of the world we know today. There was no light in the sky so the Great Turtle again called the animals to council. The Little Turtle was the only one who could take the light to the sky. With help from the powers of the other animals, she collected lightening, put it in a ball, and took it into the sky to be the sun. She then made a smaller ball to be the moon. Thus, the female Turtle made the sun to give us life in the form of food and light of day, and the moon to provide some light at night. Other Indian tribes believe it was a female turtle, not a female toad who brought up the first earth.

the world was created

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and took her to the Great Turtle, master of all animals.

He called a council to figure out how to bring earth up to make an island for the woman. Many animals tried, but died in the attempt.

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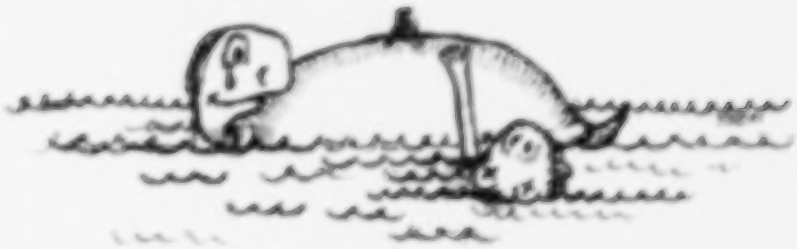
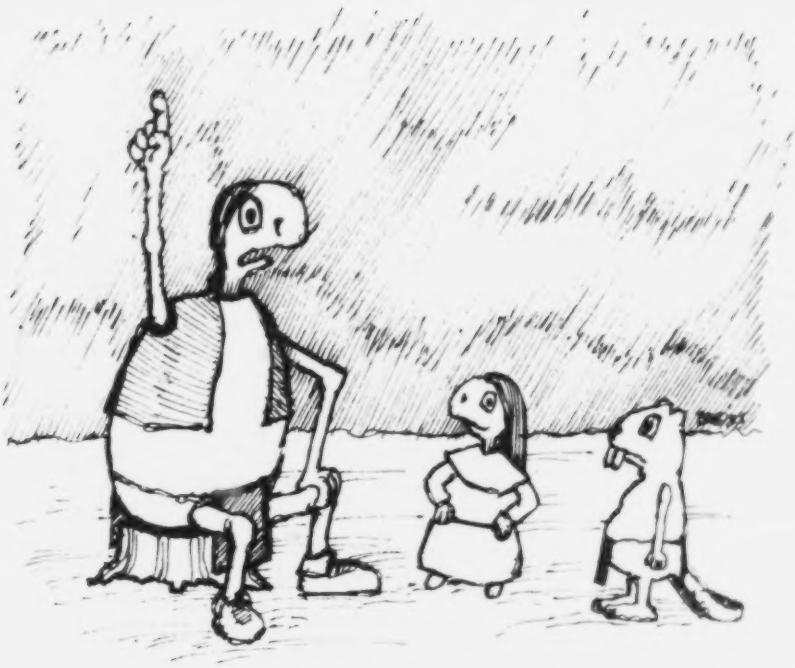


She put it on his back, and then died from exhaustion.

The Turtle then supported the earth on his back as it grew into the island of the world we know today.



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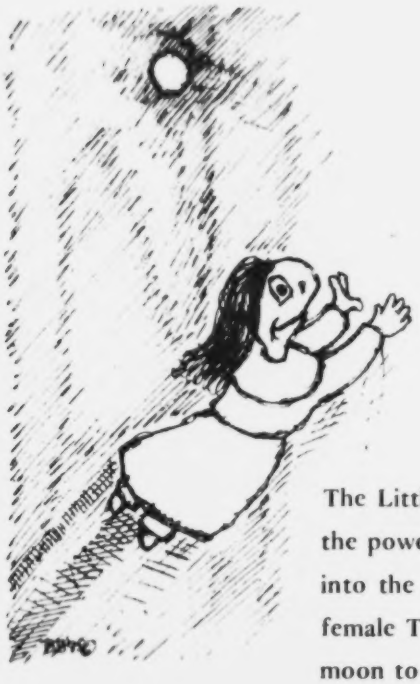
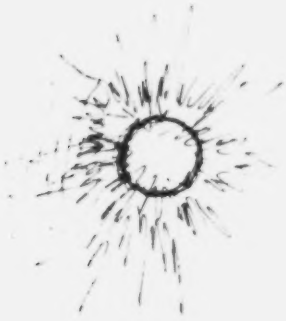




The Little Turtle was the only one who could take the light to the sky. With help from the powers of the other animals, she collected lightening, put it in a ball, and took it into the sky to be the sun. She then made a smaller ball to be the moon. Thus, the female Turtle made the sun to give us life in the form of food and light of day, and the moon to provide some light at night. Other Indian tribes believe it was a female turtle, not a female toad who brought up the first earth.

I, Lois Steele, like the Old Lady Toad story better. In this modern world which worships youth and beauty, it is good for us who no longer possess either, to have an Old Lady Toad as the heroine of the creation of the Earth. She portrays characteristics many tribes encourage in their women, characteristics that true medicine women of today should think about:

(1) Courage - to face the unknown, be it the unknown depths of the water covering the earth, or the alien environment of medical school and upper and middle-class America.

(2) Industry - to swim far enough down to get the earth; or to work hard enough to finish professional school and yet fulfill duties as a mother, sister, daughter and grandmother.

(3) Generosity - to give your life for a "woman who fell from the sky" as did Old Lady Toad; or to give of your skills for those who need help.

(4) Loyalty - to your people, to your leaders, and to your dreams.

Improving the health status of Indian people is a major factor in determining the future of American Indians. The Indians Into Medicine (INMED) Program was developed out of concern for, and by representatives of, the populations of the twenty-two (22) reservations in the INMED service area of North Dakota, South Dakota, Nebraska, Montana and Wyoming.

One of the major factors contributing to the success of the Program is the tribal involvement and Indian control. INMED is governed by an all-Indian Advisory Board of tribal appointees representing 23 tribes in INMED's service area, or about 100,000 Indian people. The Board has provided direction, policies, and priorities for INMED.

There were about 40 American Indian physicians identified at the time the first Indians Into Medicine (INMED) grant was written. In 1970, only 18 American Indians were enrolled in medical schools across the country, none at the University of North Dakota. Dr. Lionel deMontigny was at the time the only Indian medical graduate of the University of North Dakota; and only one Indian, a female, was enrolled in undergraduate premedicine at UND. She dropped out of school! The reasons were varied, including illness in the family, academic problems, and perhaps lack of others with similar interests. Suffice it to be explained by the reasons we still saw a need for the WEEA Program and the reasons we wrote this book years later.

The INMED Program has been in existence for twelve years. Since the inception of the program, 45 health professionals have graduated from the program, including 37 physicians, one dentist, two nurses, one physical therapist, two health educators, and two Masters of Public Health. Another 35 INMED students are still in professional schools of nursing, medicine and clinical psychology. Today, the total number of Indians in medical schools across the nation is 258, but Native Americans are still the least represented, percentage-wise, of any minority in the United States.

Over 350 students from junior high school through medical school have participated in various facets of the Program in these twelve years. A startling fact emerged as data was compiled in 1981. Many girls were recruited at the junior high and senior high levels, and female applicants were usually better qualified on paper, i.e., test scores, grades, recommendations. However, far fewer women than men apply to the INMED college and professional school program, indicating that the women are not persisting in their endeavors in the math/science fields. In 1981, the INMED college student mix was a 3 :1 ratio of males and females. The applications for the Summer Institute from junior high students for summer 1981 were at a ratio of 4 :1, females to males, and the high school applicants' ratio was 2 :1, females to males.

The Association of American Medical Colleges (AAMC) has reported that 21 American Indian or Alaskan Native women entered the United States medical schools in fall 1982, fewer than any other female ethnic group. The number of Indian women seeking medical training is decreasing, while the number of female students from the general population applying to medical school is increasing. Only 4 of the 25 medical students participating in the INMED Program during the 1984-85 school year are women. The OHOYO Resource Center estimated that there are only 49 American Indian/Alaskan Native women physicians nationally.

It is apparent that Indian women are running into problems unique to their sex. The problems occur prior to their matriculation into college, or soon after they enter. Similar problems seem to affect women from the general population, but the barriers to Indian women continuing formal education are more severe. For instance, the ratio of females to males in the University of North Dakota School of Medicine is presently 1 :3.5. As noted above, the ratio is 1 :6.4 for Indian students here. Nationally, admissions of women to medical schools increased 5.9% in 1982-83 to a ratio of 1 :2.2, females to males.

What is discouraging American Indians from continuing to aspire to the highest health careers? Are American Indian women also victims of double discrimination and stereotyping? Are there cultural differences that make the problems of Indian women very unique, especially for those pursuing the highest health careers? These and other questions prompted the INMED Program to seek a grant from the Women's Educational Equity Act funds. We are now offering some answers, and hopefully some solutions, in the book before you. True, all we have tried are "band-aid" solutions, but that is more than we had been able to do before the WEEA grant.

What are the "band-aid" type of solutions? Well, before you find solutions you have to have an idea of the questions and problems. We asked Indian female students why the majority of their peer group was not making the transition to college life smoothly. The following are sample comments and answers from our women students which prompted the development of the "band-aid" program which allowed us to reach the goal of helping our women through their painful transitions:

> "I have problems dividing my time between my studies and my family."

"The way I was raised has put me in a lot of conflict, especially in raising my son."

"This year is my first year in professional school and the competitiveness has sure gotten to me."

"My husband won't move up here, (from the reservation). He doesn't support me financially. He says I'm selfish and have deserted my family. He calls me (on the phone) with an ultimatum: 'school or him'. I'm currently seeing a counselor across campus." (The student went on to explain that her counselor is not Indian and only partially understood the problem. This student eventually went back to her reservation).

"When I first started college and learned more about the academics and such, my husband was often asking me questions he knew I couldn't answer; then he would say, 'well, you should know, you're going to be a doctor.' After he started college a year later, it seemed like he was competing with me. I don't want to compete with him, but I find myself falling more into that sort of situation."

"My boyfriend doesn't want to marry me because he doesn't feel that I can be the kind of mother he expects for his children. He doesn't remember his mother ever having to leave the children with babysitters, as I have to do with my son."

"My mother calls me with family behavior problems, she says 'doctors should know how to handle this.' I'm only in undergraduate pre-medicine."

"I was raised where Indian men did not have to do dishes and weren't expected to help with the housework, but if he doesn't help me, I can't get everything done."

"The other Indian men that he runs around with don't help their wives around the house and he's questioning my insistence on some help."

"My mother expects me to come home for all the funerals, wakes, etc., but I can't do that and keep up the grades the way I should."

"Medical students are selfish with their time with other people. I can't be selfish with my friends."

"He has children from another marriage, which he expects me to be able to take care of as well as our children, and yet, it is very difficult to do this, and also finish my thesis and try to compete in a professional world."

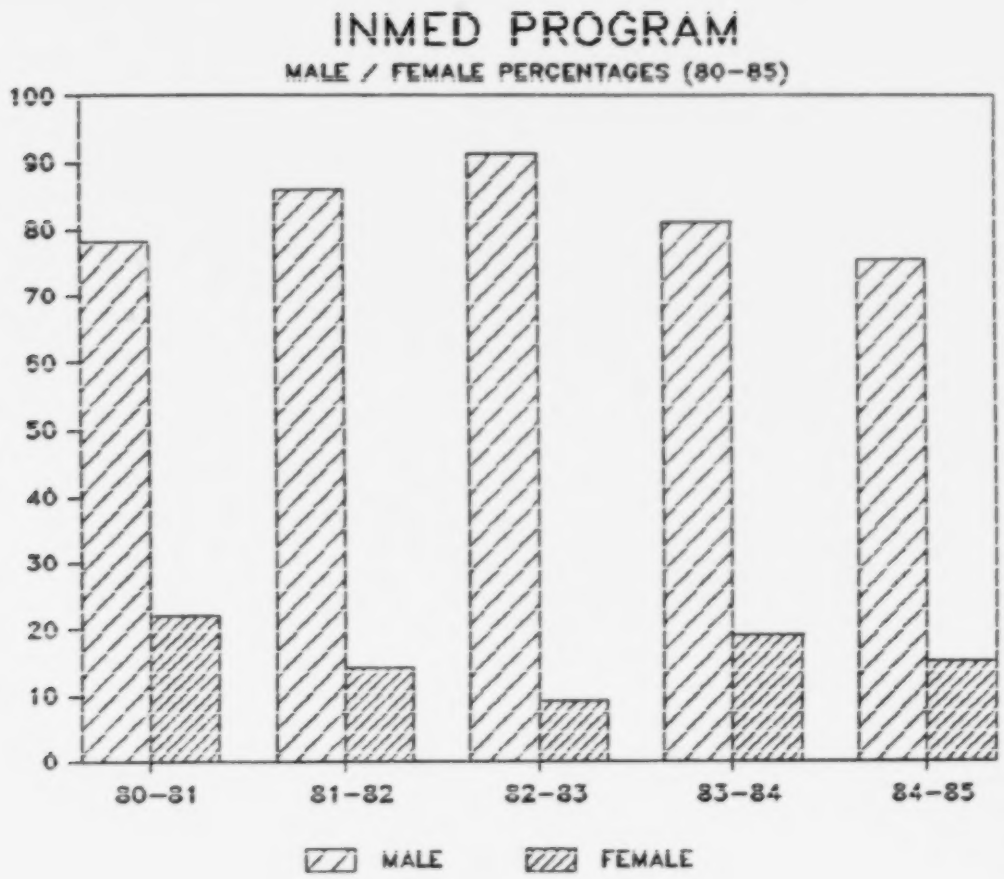
"He never used to hit me, but I am becoming frightened of him."

"My sister went in for alcohol treatment. She could not have gone unless I took care of her two little ones. On my financial aid there is not enough money to cover us all and welfare won't help. But as the eldest sister, she trusts me and it is my role to help her."

Some of these problems are not unique to Indian women, however, particular roles ascribed to women on reservations have been tribally-dictated for many centuries. The lack of women professionals on the reservations as role models appears to have put Indian women years behind non-minority women in pursuing medical education. The barriers to Indian women's professional development are very real. The support systems are just developing that will allow Indian women to reach their potentials without undue sacrifice.

Our studies during the 1982-83 year have lead us to some conclusions. In many cases, due to time and money constraints, we were not able to quantify the conclusions. That task remains for a more ambitious research project with more than one year of funding. Our prime intent was to apply solutions in a "band-aid" type program to immediately salvage as many female students as possible, and to lay ground work for long range changes. We have done this, as evidenced by the 1984-85 figures which show a total program*male/female ratio of 1:2, versus the 3:1 male/female ratio in 1981. There are four INMED women in medical school versus 2 in 1981. The following graphs attest to the success of WEEA.

*graduate and undergraduate college students.



GRAPH: INMED Medical School students male/female percentages for 1980 through 1985

SUMMARY

In every year since 1980 percentages indicate that the male medical student has had the higher percentage each year. Whereas the female medical student percentages fluctuate; the highest being in 1980-81 at 22% and the lowest at 9% in 1982-83. This fluctuation for females may be explained by the number and interest of females in medicine. Each year INMED receives more male applicants than females and until recent years, the INMED undergraduate program consisted of a higher number of males than females. Future projections indicate an increase for females in health professional programs due to the greater number of females in INMED's undergradute program.

Compiled by: William Gourneau
Research Analyst
INMED Program
November 1984

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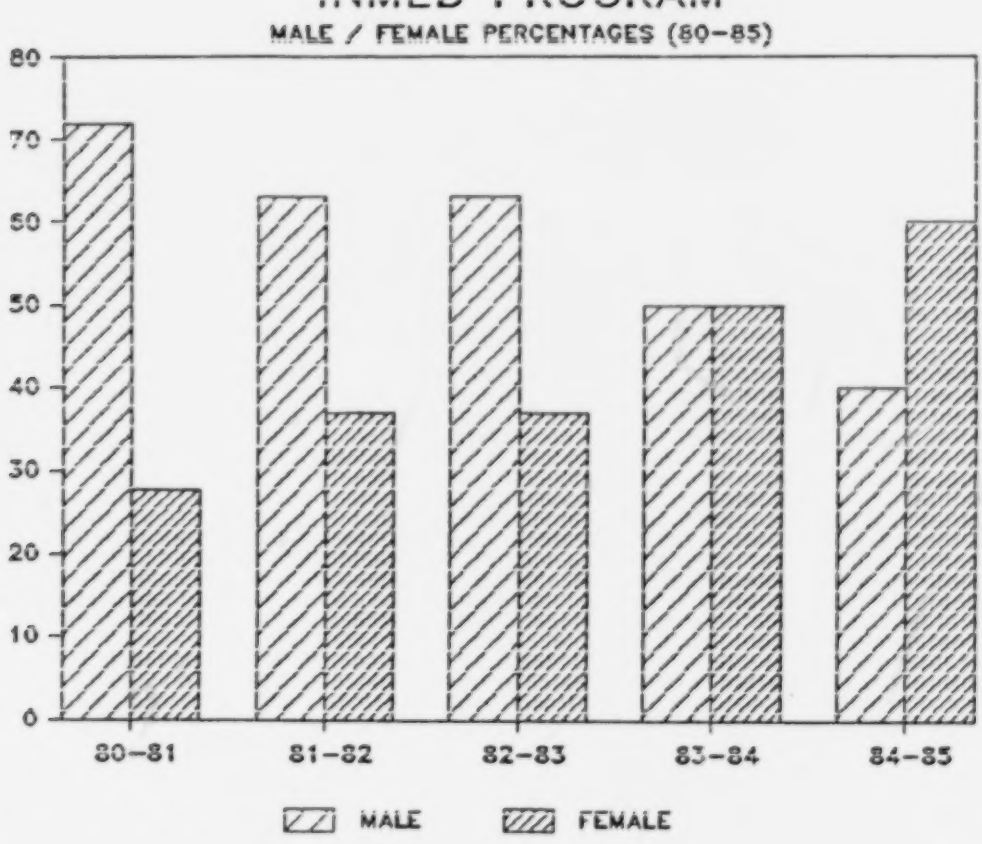

GRAPH: INMED Undergraduate students male/female percentages for 1980 through 1985.

SUMMARY

As shown above, there is a steady increase of percentage for the female undergraduate students. This indicates that more females are becoming interested in pursuing a health career. These percentages have been useful for our program in projecting future health professionals.

Since the awarding of the Women's Education Equity Act (WEEA) grant in 1983-1984, the number of females participating in the college portion of the INMED Program has increased to twice the male participation. Several factors are allowed for this increase:

1) The support services WEEA provided the women in securing housing, child-care and social services.
2) Activities to enhance self-image, physically and emotionally, which prevented many drop-outs.
3) Indian Health Service emphasis on funding nursing scholarship applications rather than other health careers except medicine in the past two years.
4) Better recruitment contract secondary to the large OHOYO Conference held at Grand Forks, June, 1983.

The WEEA grant was funded only one year and the INMED Program has made remarkable gains during that time.

Compiled by: William Gourneau
Research Analyst
INMED Program
November 1984

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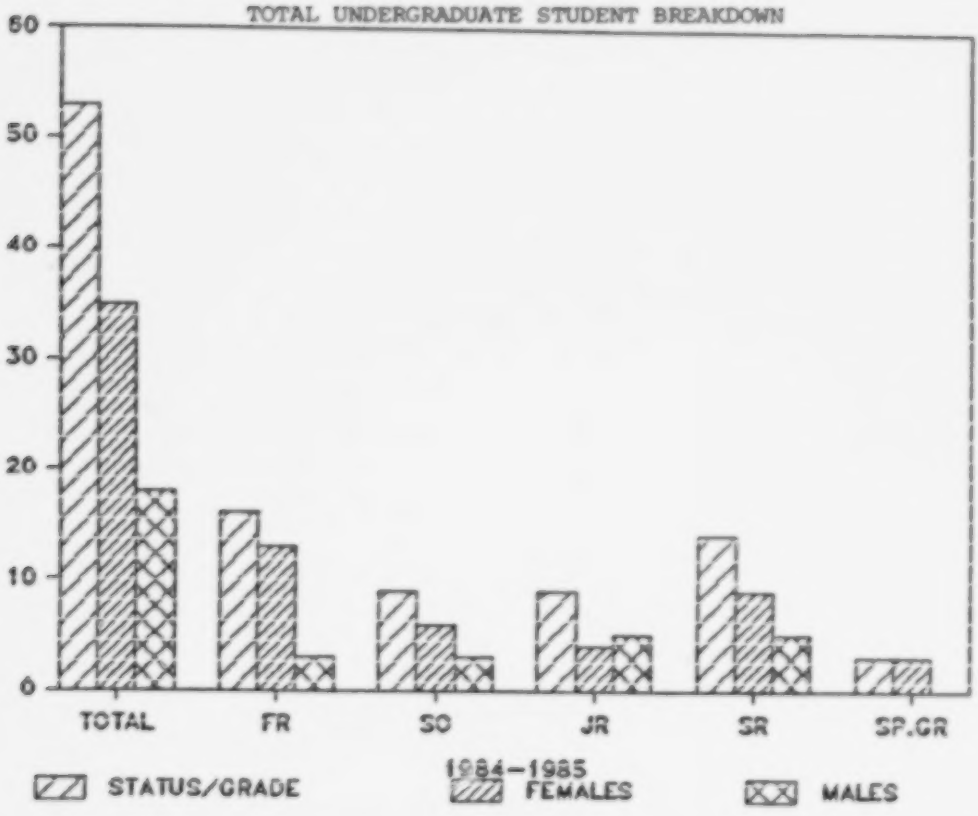
INMED PROGRAM



GRAPH: INMED Undergraduate Student breakdown of total number and as per their classification, includes students directly and indirectly funded by Indian Health Service Scholarships.

SUMMARY

Total represents the number of students (53), the INMED Program assists either directly or indirectly. It also breaks down the total number of females (35), and males (18), that when combined make up the total number of students directly or indirectly assisted by the INMED Program. From the total, students are placed in their classifications for a total breakdown of male/female per class. The Freshman and Senior classes show the highest numbers at 15 students per class, further examination shows 13 of the total Freshman class are females. Females outnumber males in all classifications except the Junior class and are only slightly below. Totals of all classifications indicate an increase in female interest towards pursuing a health career, and projections for females achieving their health career are increased.

Direct Students receive the 437 Indian Health Service Scholarship and support services of the INMED Program.

INDIRECT Students receive support services from INMED through Health Careers Opportunity Program (HCOP), but recieve scholarship funding from other sources such as, BIA, PELL, Workstudy, North Dakota Indian Scholarship, etc.

Compiled by: William Gourneau
Research Analyst
INMED Program
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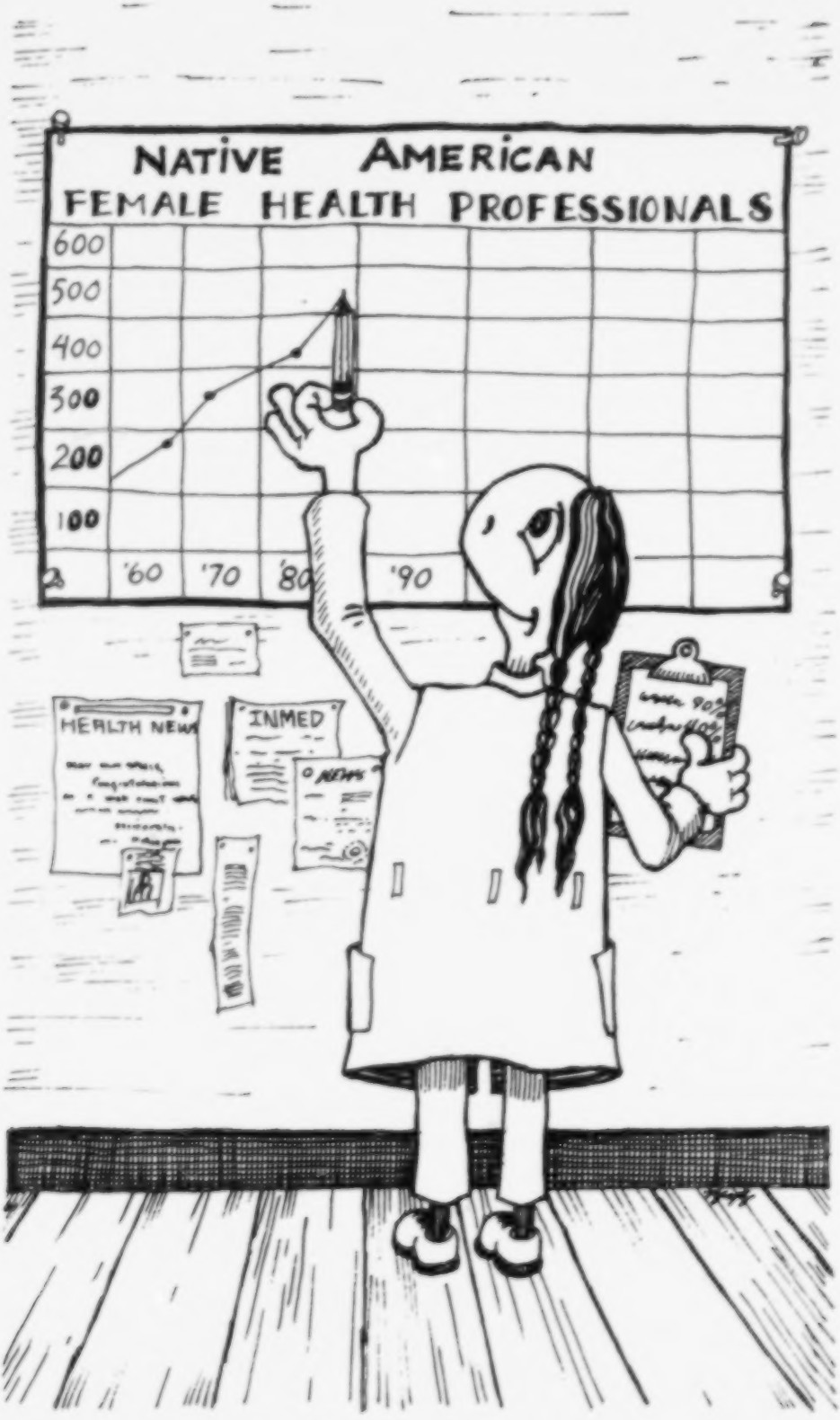
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HEALTH NEWS
INMED

Some conclusions as to why some Indian women may abandon their health career plans are listed below. These are generalized conclusions, and many exceptions to each one exist.

(1) Women are expected to and do have children earlier in the Indian world than in non-Indian society.

(2) Many of our girls are mothers, often single parents. Children are usually shared by the extended family so there is less push to marry over an unintended pregnancy than in some other groups.

(3) Materialistic objectives are not as relevant in the Indian family. Consequently, the insecurity of family-pattern and spouse-relationship interruptions is a decisive factor in disrupting marriages. The materialistic concept of "marrying a rich doctor" is not able to hold the relationship together, when the spouse is in pre-medicine or medical school.

(4) The Plains Indians culture is more present-directed than most other segments of society. Deferred gratification is not taught early and this also weakens relationships and goal orientation during the arduous task of medical school.

(5) The fear that women will become "too intellectual" and leave their men and family emerges as a recurring theme among our students. Some of this stems from a basic insecurity of men, which is usually long-standing and a consequence of the discrimination and set-backs Indian men have faced. This situation has been noted in other minority groups also, and women tend to see it as more of a barrier than Indian men say there is. The women that do the best emotionally in medical school are those who can ask for and accept help from people who love them, especially their significant others.

(6) A mother's attitude toward her daughter's education seems to be a key factor in the process of discouraging or encouraging the daughter to go on in school and career.

(7) The importance of the extended family, and a woman's role as mate, mother, daughter, and grandmother, overshadows her role as a health provider. She was raised to provide a type of strength for her family. Many girls relate that they are too exhausted emotionally to fulfill all the roles expected of them. This may explain the importance of the mother's attitudes. Mothers that help their daughters the most seem to share the roles and burdens expected of the daughters.

(8) Indian families operate on "Indian time". This is flexible, and results in activities starting later than scheduled. The result for our women is that planning and budgeting time is even more difficult than it is for non-Indian persons studying the difficult math/science curricula.

The frustrations of a student waiting for someone to come home to babysit so she can study are made worse when she's told, "you do not act Indian any longer" (due in part, to the emphasis on time).

(9) The sharing required in the culture results in much time spent preparing for potluck dinners or pow-wows, and interacting with children.

(10) Indian women, and all women, need to feel that their children are being raised to function well within their own culture. Indian children are raised permissively, with an expectation from a very young age that they have the right to be treated as individuals. This is a subtle but important difference in child-rearing that enables the child to develop his/her individuality and personality without direct interference from family members. Authoritative direction of children takes less time and attention from a caregiver than does this permissive child rearing. In the later situation, children learn by experiences rather than being told, "this is the way it is, I am right!" Providing and directing experiences takes more time than specifically declaring what a child will do.

(11) The type of competitiveness required to attain the highest health professional status has not been sanctioned in the past by most Indian cultures. Women are allowed to attain different types of social status, but are not encouraged to compete, with little or no cooperation between them. Medical and pre-medical training programs have tried to minimize destructive competitiveness, but it still exists, and is ruthless in most schools.

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CHAPTER II

COMMENTS ON THE ROLE OF INDIAN WOMEN IN HISTORY

The health care industry is an amalgamation of technology, healing, caring and business. [1]The history of women as health care workers is characterized by professional promise and progress in conflict with male medical bigotry. [2] In 1873, Dr. Edward Clark, a Harvard medical professor, stated that the end result of medical education for women could be "monstrous brains and puny bodies, abnormally active cerebrumation and abnormally weak digestion flowing through constipated bowels."[3] More than 100 years have passed since Dr. Clark made the preceeding statement, and the status of women health workers is still lagging behind their male peers. Although the health care industry is run on woman power (87% of health care workers are women), it is controlled by a relatively small cadre of predominately male physicians and administrators.

While the plight of women in non-Indian society has been one of inequality (which has been recently challenged), Indian women have for the most part shared equality of position in important matters in Indian society, until the reservation system was enacted.

> Both females and males can pledge to do the Sun Dance. The dance cannot be done without the presence of a virtuous woman to represent the White Buffalo Calf Woman ; the sacred woman who helped Sioux in the time of need.
>
> Women have long held and directed leadership roles in most tribal governments. Presently, 67 Indian women are in current leadership positions in tribal government out of over 500 tribes. The first recognized record of a true American Indian woman leader was in 1540 in the De Soto journal. A council of Navajos had women members who could veto war. One fourth of the Indian societies were matrilineal in 1492.

[1]"Women in Medicine", Health Careers Network, Vol, 1, No: 4, August, 1982, p.1.

[2] Ibid, p. 1.

[3] Ibid, p. 1.

> There is little written about the women leaders because of the mind-set of the European trappers and missionaries. The Indian female role was misinterpreted by the patriarchal early European settlers in this country. They didn't recognize the matrilineal perspective of many tribes which convey to women a great deal of power. Some Indian cultures are also matrifocal. The mother role is culturally elevated and structurally central. The daughter takes the husband to live with her at her mother's house.
>
> As mentioned before women have held leadership positions as tribal council women, chairwomen and official advisors to tribal governments for centuries; long before other women could vote in this country on governmental issues.[4]

This misunderstanding by the outside society has continued. As Phyllis Old Dog Cross states: "Indian females have to reclaim it (our heritage of autonomy). We've been against a lot of other stuff, but we've never been relegated to the 'stay-at-home, watch TV, and don't try to be better than your husband's role'."

Yet, we Indian women are cautioned by grandmothers, "Men are fragile. They grow up late!" The strength of females is emphasized! Even in the Sun Dance, women can give flesh but do not have to prove bravery. They can give birth to children. Men traditionally turn to grandmothers for nurture and advice. Traditionally, Indian women had equality, but as Indian people become more "mainstreamed", we have picked up many of the ideas of the outside world.

If a couple decided to split up, in some tribes where the women owned all of the property, the women simply put the husband's saddle outside the door. We are seeing a return to this with the five dollar divorce on some reservations. Divorce was easier and more accepted, with social customs to aid in rearing children. The role of the uncles in training young boys, and the role of brothers in providing for their sisters who were alone, were stated clearly. The eldest sister's role in her brother's ceremonies was important. There were definite sex and family roles. All family members had roles and tasks, until formation of reservations, when the role of the male became unclear. The role identity of the Indian woman was preserved, because her tasks changed the least. This may be the reason that grandmothers born about 1900 cautioned their granddaughters, "men are fragile." Originally, the roles were equal but different. After reservations, the ego strength of the male was attacked by lack of jobs, loss of freedom to hunt and roam, and a disrupting foreign system of government imposed from the outside. The idea that a woman belonged to the man as a piece of property was not prevalent in pre-reservation Indian societies, hence divorce was easier, and has remained so until the present. Wife abuse was not common until recently, although in some tribes there were prescribed ways of dealing with infidelity.

[4]OHOYO Resource and Training Manual, 1982.

Many of my quotes and ideas come from discussions while writing the OHOYO Training Manual [5] over a year ago. I would recommend the manual to you as a means of understanding how some Indian females help other women to understand and cope with this diversity of Indian and non-Indian worlds, in areas of business, politics, etc...

Other scholars have better explained the sociological relationships of Indian people. It is necessary to again point out that, for the most part, our Indian men have treated us as equal in the past, and I have faith in their continued help for the future.

"Feminism" as an agenda does not fit for a lot of Indian women. My sister, Kate Vangan, talked about this eloquently in the PLAINSWOMEN, Vol.7, No.4, Page 3. The theme is that sovereignty must be our agenda. Without tribal identity and the rights of tribes to act as sovereign nations, Indian people become swallowed up and digested in the United States. Some call it "mainstreaming", but following digestion, the residue is a far cry from that originally swallowed. Indian women must understand this situation and support tribal sovereignty, always working to restore the equality with men we once had and are now struggling to protect.

Despite some feministic words, most Indian women have a determination to first stand by our men in the quest for sovereignty as Indian people. It is not coincidential that the main Indian rights activists within the system are women, i.e., Ada Deer, Pat Locke, Bea Medicine, Claudine Bates Arthur,Ramona Bennett,LaDonna Harris, Robbi Ferron, Phyllis Old Dog Cross, Twila Martin Kekahbah, and others. Most of us agree that if we had to chose between sovereignty of tribes and feminism in the radical sense, we must support tribal sovereignty. We need to work with other feminist groups to continue to improve educational opportunities and equality in wages, and to protect the gains in health and child welfare made during the last 10 years. But we can not do so at the expense of our own tribal identity and soveregnity, or we could lose more than we gain. I feel we can work effectively in both arenas as long as we are cogizant of the inherent problems. A realistic example of the problem that can arise would be: If your tribe culturally does not allow abortion, you must support the right of the tribe to make that decision, regardless of your agreement on the issue. This scenario is different from that of an outside group imposing its beliefs on tribal members.

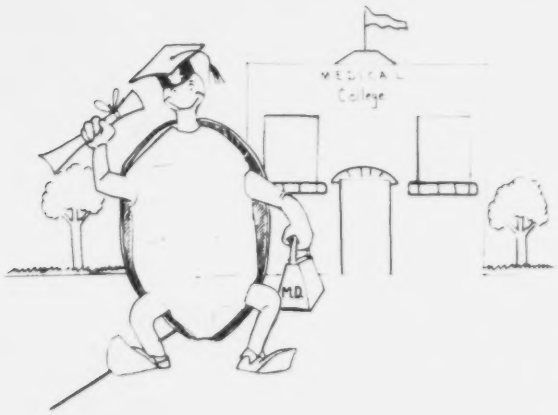
This faith in equality does not always serve Indian women well in the world of medicine. The traditional role of women as nurses, and male physicians as "gods" does not promote equality, or even inherent respect. Coping with this system is easier in a hospital where the physicians have less to prove. It also seemed easier to me when working with Jewish doctors. I do not understand the male/female interactions in the Jewish world, however, I know I have personally found that Jewish male physicians are much more willing to give respect to the females that they work with at all levels

5Anderson, Owanah; Verble, Sedelta; Walton, M. Frances; OHOYO means woman in Comanche. The Training Manual was printed and distributed by Women's Educational Equity Act.

than are other non-Indian men. If nothing else, the Jewish sense of humor is a bit closer to that of the Northern Plains Tribes, and you can laugh together. A key to getting along in a culture seems to be understanding the humor. This may be hard at times, especially if you take yourself too seriously, or worse yet if you fail to grasp the cultural metaphors that prompt the laughter.

> "A cultural metaphor conflates numerous individual symbols into a single great symbol or a small set of core symbols that in turn organize the entire society.[6]

The statement above made me rethink of INMED in August, 1984. We had started out ten years previously looking at a little turtle; thinking of ourselves as not being time-oriented, but knowing that we would reach the end of the race as the turtle does in the allegory of the turtle and the hare. The INMED turtle was a unisex turtle, neither male nor female, and he/she looks at all the health careers with the idea of returning to the reservation.



Taken from INMED Program Colorbook, copyright 1982 by INMED Program-University of North Dakota, OEO Contract No: 80902-G-73-01.

After many years of studying very hard. True Heart became a doctor.

We recently published a new brochure on the INMED Program. Instead of including a collage of pictures of various student activities or very tailored designs, we emphasized the various aspects of the Program with True Heart the Turtle; again returning to our roots to re-examine what INMED is all about. He/she is our cultural metaphor.

[6]Stein, Howard F. Ph.D., Hill, Robert F. Ph.D., Continuing Education for the Family Physician, Vol. 19, No : 8, August 1984, p. 428.

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The INMED Program's aim is to develop the strongest, best cadre of doctors possible, who will serve Indian people everywhere. Our main thrust is the underserved reservation, but that does not limit our students just to reservation service. We do attempt to select students that can serve the Indian community willingly, happily, and competently. Students applying for the INMED Program should examine their dedication to : working with Indian people willingly ; working hard to achieve the health career degree ; and maintaining an Indian sense of culture and humor in the midst of some of the heaviest acculturation that an Indian person will undergo, i.e., medical school.

Medical school's culture demands conformity, and it is important to have a good grasp on your own identity prior to enrollment. Women have made strides in medical school enrollment the past ten years, but minority women are still the targets of those professors most resistent to change. Indian women report that destructive discrimination comes from male physicians who immigrated to the United States, especially those from British Empire countries. This is not surprising! The history of the non-Indian with Indian people goes back two hundred years. Author Joe Sando, Jemez Pueblo, delineates it well. The French and Russians married Indian women. The Germans studied us! The Spanish came to an uneasy peace with the Southwestern tribes over commonality of the Catholic religion. The British wanted Indians away from them, across the Mississippi, in Indian territory Oklahoma, on reservations, anywhere, but close enough to touch!

This is not a document of denunciation. It is a survival manual for Indian women in medicine. I only warn you to be careful. Discrimination is seldom blatant. Until you have lost the battle, you may not have realized you were fighting.

Now Dr. True Heart the Turtle goes home to work among his people.

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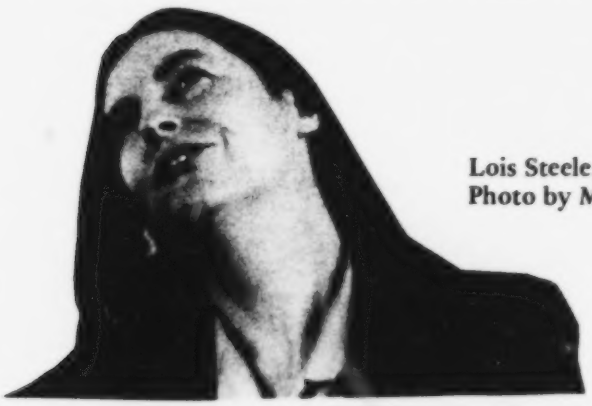
CHEM
M.D.

CHAPTER III

REFLECTIONS OF AN INDIAN WOMAN PHYSICIAN



Lois Steele, M.D.
Photo by Mark Best, 1982

I am an Indian woman physician. The title of this book, MEDICINE WOMEN, encompasses more than that description. Few of us are truly "Medicine Women" in the traditional sense. There are opportunities to become more knowledgeable in traditional medicine, however, the dedication and time limits are prohibiting. It is easier to become women in medical professions than medicine women in the traditional Indian sense.

I was at Lac La Croix with a medical team and one of the men from the village asked me, "Are you a Medicine Woman?"

I laughed and said, "No! I don't know enough! I only know some about white man's medicine."

It was an uncomfortable situation. The medical team flew up to this isolated village periodically on church and university funds. The main thrust was to preach to the Natives after seducing them into the school with some cartoons. The following day clinic was held and patients were treated.

The scenario was unknown to me when I was asked on the trip. It is always nice for them to take a token Indian medical student, and I was glad to see Indian patients. I did not realize that the other activities were to occupy the important place they did on the trip. If I had known, I probably would have refused to go. I was refusing to be a part of it all at the time the man asked me if I was a Medicine Woman. I was outside sitting alone, rather than watching the cartoons or listening to the patronizing sermon. I hope the man understood, he seemed to.

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He smiled and nodded, this seemed to be an acceptable answer for him. The answer should be acceptable to most Indian women physicians who respect the wisdom and talent of the Holy People and Shamen among us. We must respect the traditional healers and work with them to help our people. There is no room for "Queen Bee's" in the world of Indian women physicians; there is too much work to do. Work gets done better when many talents and backgrounds are pooled together.

What talents are needed to become an Indian woman doctor? On the following page is a letter I received after writing to a non-Indian physician in 1969 regarding my hope to attend medical school. He had served on my reservation and had asked people in the community why there were no Indian physicians. He had seemed sincerely interested in helping to develop a cadre of Indian health professionals. He had finished his required service and left the reservation when he wrote the following letter. (NOTE: his name has been removed as I have not been able to locate him to let him know I did not become discouraged in pursuing a medical degree, and also that the 3.75+ grade point average was good enough after all.)

COUNTY PROFESSIONAL BUILDING
M. D. P. O. BOX PHONE M. D.
RESIDENCE PHONE MONTANA 593 RESIDENCE PHONE
MONTANA MONTANA

April 23, 1969

Lois Steele
Box 1062
Poplar, Montana 59255

Dear Lois;

Thank you for your letter of April 2nd. 1969. I am sorry to have been so long in replying, however, as usual things have been exceptionally busy, and I have not had a chance to get to work on your problem as best as I might have. I have written to the Dean of Admissions at the Yale University School of Medicine, who is a personal friend of mine. I have discussed the matter of admissions with him just this past month when I was visiting in New Haven, and I think it is fairly clear that you will not stand much of a chance to get into any medical school this year unless some of the medical schools to which you have applied change their acceptance or rejection or their waiting list priorities.

As far as future possibilities are concerned, I cannot offer you too much hope because as you say in your letter your age and the fact that you have two children is not a desirable characteristic for a medical student as far as medical schools are concerned. Unfortunately, medical school is not like the average graduate school. You will find that your work day, even in the first and second years of medical school will last 10 to 12 hours a day, and perhaps even longer. This will mean a considerable amount of time away from home and away from your children. When you get into the third and fourth years of medical school, namely, into the clinical side of medicine you will find that your time with your family and at home decreases even more. This is of course more of a personal consideration rather than an academic consideration, however, it is one that I think most medical schools will take into account when dealing with your application. In terms of the medical school market, in other words, what kind of application yours is among all the other applications for medical school, you do not rate particularly high. First of all, your age and family background does contribute to your desirability for medical school, and of course your grades and your performance on the medical school admission tests also contribute to your desirability. As you state, your grades are good, but not as good as they could be. The majority of students that are getting into the medical schools today have quite high grades, and score quite highly on the medical school aptitude tests, although this is not universally so. For example, my own admission to medical school was primarily by luck, and not by any skills that I happened to possess as far as having good grades or passing tests. The philosophy of medical education is also changing, and I think that medical schools are striving to get younger and younger people into medical schools even before they have finished four years of a baccalaureate program. So all in all, as far as your desirability to a medical school is concerned, when compared to other medical students, things look rather bleak. However, I do not think that you should give up hope entirely. The reason being that medical schools like many other organizations need to have a few people in their organization who do not fit the run of the mill picture of medical students or doctors. This you certainly do, and I would think that if you make your applications to the appropriate places, and I can probably give you some better idea about this after I hear from Dr. Forbes at Yale, you would probably stand a better chance of getting in. Many of the schools which you have applied to have quotas as far as their out of state students are concerned. These schools, namely, the state supported medical schools are obliged to take the majority of their medical students from the state which supports them. Only a small percentage, and usually a very high ranking and well qualified percentage of their students come from out of state areas. For this reason, you may do better applying to a private medical school

I will certainly be in touch with you. I encourage you not to become discouraged.

Sincerely,

M. D.

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A VISTA worker from Stanford told me about the Medical College Admissions Test (MCAT), and that general knowledge was an important section.[7] That section included questions on opera, art and literature. He gave me a crash course in opera and art. I scored well! This was despite the fact that I thought Bill Standing was the world's greatest artist, with Charles Russell a close second. I had never seen a real opera in full costume, although I had been lucky enough to have taken a humanities course from Alice Ryniker at Rocky Mountain College. Actual preparation for the MCAT, aside from the obviously-foreign opera and art areas, never occurred to me. I had been out of school for awhile. My scores were in the middle range, and adequate enough to be competitive.

Another local doctor, Charles Larsen, M.D., took an interest and taught me enough about applying to medical school that I was interviewed by Wayne State Medical School in 1969. That interview reiterated and expanded on the remarks of the previous letter from the physician who had worked at Poplar, Montana. I was labeled a poor risk, because American Indians did not do well in medical school. Women did not practice as much as men after they received their M.D.'s, so we were called poor investments. The few thousand dollars I had saved was not considered to be enough money. Divorced women were unstable in the eyes of the admissions committee, according to the man that interviewed me. Mothers should be home with their children. Of course, the one man that interviewed me said he realized that I probably did not fit all those stereotypes. He said he felt that I would be a good candidate, however, he doubted he could convince the whole admissions committee of this. I wish he had realized his doubts before I had spent all that money to travel to Detroit. The reasons he gave for my non-acceptance were all on the application, i.e., age, race, family, and income. I asked him why he had even interviewed me since he already knew the committee wouldn't accept me. He replied, "the committee was curious! They don't have many applicants like you." Their curiousity cost me hard earned money!

It is true that women physicians generally work fewer hours than male physicians, even today. "Women physicians in practice work 7.9 fewer hours (per week)than their male counterparts according to a new AMA study. They also see fewer patients on the average, 18.5% fewer than male physicians."[8]

A medical education costs about $100,000 in today's money for tuition, living expenses and other educational expenses. The average debt in 1984 of a graduating medical student is said to be about $20,000. This will change the type of student we see in the future. The average debt is increasing each year as grants for students decrease. This topic of financing a medical education is deep and vast, and is the topic of other books. The problem is simply that the privilege of a medical education still remains a privilege.

[7]This was the "old" medical college admissions test. The test was revised after 1969 to make it more fair to all Americans.

[8]The New Physician, September, 1984, p. 24, American Medical Student Association.

The service payback scholarships of the National Health Service Corps and the Indian Health Service have enabled some of us less-economically-endowed to attend medical school in the 1970's and 1980's. Will they be around to help low income students in the 1990's? What kind of "privilege" will medical education become?

American Indian students had a drop out rate higher than that of other minority groups in the early 1970's, when the first push for minority enrollment occurred. The rate is still higher than for other groups, but the gap has narrowed as pre-college programs such as INMED (Indians Into Medicine) and AAIP (Association of American Indian Physicians) have worked with Indian students, to try to assure that students are prepared for medical school and the grueling life style of a physician-in-training.

Women have been admitted to medical school in greater numbers since I first interviewed in 1969. The 70's brought an awareness of the problems women were having in obtaining a medical school position and the discrimination they were facing.

The irony was that in 1973, just four years after my initial rejection from medical school, ten medical schools were interested in me. I decided on six interviews out of ten schools. Only two of these medical schools rejected me after an interview, and I had stated during both interviews that I really would not be interested in attending there, after looking the schools over. One school was too formal, with a very rigid atmosphere, and the other was located in the middle of the largest asphalt jungle I had ever seen.

The problems delinated during the interviews at Wayne State four years earlier were still there. I was four years older, still divorced, still raising children alone and I had less than $10,000 saved. Medical schools became interested because the medical admissions world had changed. There was extra money now for schools that accepted minority and women candidates.

HE who giveth can taketh away!
(Old Proverb to think about.)

The attitudes of the majority society toward their medicine people is different from the attitudes of traditional Indians. The mainstream American society expects their physicians to be always right, and sues a physician when he/she make a mistake. The traditional healer often expects his/her "patient" to sit nearly naked exposed to the elements for four days, to fast, to think about his/her life, and to go without sex or alcohol for a stated period of time. Demands made on a mainstream patient, even as to taking medicine as prescribed, are often not met. Medical schools devote lectures to "patient compliance". It is as if the majority population group expects the doctor to do it all, then sues him/her if he/she can not. Indian patients are made to realize that they must cooperate and sacrifice if the Shamen is to help them. This attitude used to carry over to their physicians. It is eroding somewhat as Indian people become more sophisticated and acculturated in the role of the patient in American society.

The following are some of the characteristics that should make Indian women health workers more comfortable in majority medicine:

(1) The concept of the extended family can give much needed emotional support when things go wrong. The more people who accept you as you are and appreciate what you do accomplish, the more emotional strength you will have in reserve when you can not accomplish it all. Too often, the mainstream society lends little emotional support, then wonders at the number of impaired and bitter physicians.

(2) Children are "O.K." to have around the Indian world. They are not hidden and put in their own niche. This helps an Indian mother to reconcile the small amount of time for social events and family. Most Indian social events have children in attendance. This is not true in much of the majority society.

(3) Women are respected for what they can do and are not expected to take on male characteristics when they occupy leadership or medicine positions in the Indian world. This gives a better feeling of security as a woman and strengthens self-identity.

Some reflections on being an Indian woman physician change over time. The following are some I jotted down when on a long trip to visit students that had transferred for their third and fourth years of medical school.

"Would you do it all again?"

Graduating medical students have asked this question of each other many times. Surprisingly to me, the Indian physicians are more apt to say "yes".

Dr. Janice Wallette, a Turtle Mountain Chippewa, pondered her answer, but she still was more positive than the non-Indian women who graduated from medical school with me. I was not always sure of my answer, but was still not as negative immediately after graduation as many other women in my class.

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The differences in responses may lie in the observation that the reservation-raised women in medicine often have children by the time they are in college and medical school. This is more prevalent than among the non-reservation-raised women. Perhaps the security of having met some family expectations prior to aspiring to practice medicine reassures us that we indeed meet the definition of "Wein Was'te–Good Indian Woman" role.

One of the most difficult problem areas for any American woman in the 80's is to define her role. The "feminine mystique" was exposed to the nation in the early 60's; rejected in the late 70's and now in the 80's is being re-examined by disillusioned career women with families, many of them single.

The revival of the traditional Native American religion, with its many ceremonies, necessitates someone making quilts, collecting trade goods for give-aways, contacting family and friends for help, and most of all, being available for four-day intervals to attend to the duties the ceremonies demand. Thus, the traditional tasks of women are also being revived. The positive aspect is that as a career woman making a good salary, you can buy the quilts, trade goods, and other items, and will only have to plan activities around the ceremonial times. The dichotomy is not insurmountable.

Back to the question, would I go through medical school again? The grueling, boredom of the first two years of medical school; the intense competition in all respects of your life from your classmates and mentors; the uncertainty of what sacrifice is necessary to be a good physician (but always being told it's more than you have given); these are some of the negative aspects.

Do I wish I had chosen a career other than medicine? It is hard to control your life and be available to administer to patients when they need you. At times there seems to be a lack of creativity. Sickness can be overpowering when you deal with it everyday.

The malpractice suits when you gave extraordinary effort do not create enthusiasm for medicine. The patients who demand respect but don't return respect to lead your own life when you are off call, can bring about bitterness. You are expected not to cry or show emotion when a patient dies, yet you are called a "tough bitch" when you refuse to come into the hospital when you aren't on call (after several days of being on call.)

A patient died! I cried! My boyfriend, a non-Indian, non-physician type, questioned, "why are you crying? You are a doctor! You know these things happen." Such a depth of understanding really solidifies a relationship. This may be a hint to the reason that most women physicians' marriages that are successful, are marriages to men who are also in some medical field.

I was at a conference sponsored by the American Association for the Advancement of Science. The conference was held to look at barriers minority women face in

their advancement in science careers. The general consensus of the women there was that there is more discrimination against you due to race when you are younger and entering the job market; but as we advance in the academic ranks, the discrimination is more because we are women. Having a husband in the same field may soften this some.

I've thought about this discrimination and I find it is still true, I do have to be twice as tough and take twice as many risks to get the job done as a male in the University would. Yet, my tribe has afforded me more respect that I ever imagined they would, and more than I feel I've earned. Indian men have taken risks to help. Both females and males are my mentors. However, we women have shared the same concerns: day care, wife and child abuse; single mother families; and role identity problems. This sharing helps us survive.

Association of American Indian Physicians Gourd Clan
at the 1984 annual meeting

This is one way the AAIP doctors help one another and give each other respect. The Indian male physicians also share so all Indian doctors survive better.

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Here are some random concerns no one discussed with me prior to my entry into medical school. We at INMED try hard to discuss such reflections with our students and prepare them for the reality of being a healer. One woman student questioned her continuing medical school after she experienced some personal problems. She stated: "No one told me medical school would be so bad. If I just knew beforehand it was so shitty, I would be able to stand it better."

I felt I had told this student that medicine was no bed of roses, but the medical school climate in 1984 is more stressful for minorities and women than medical school was ten years before. Students and faculty alike are stressed by the changes in the economics of medical practice. Federal grants for research are harder to come by. The faculty at the University of North Dakota has not received salary raises for three years, yet inflation has continued to climb. The nebulous, stressful undercurrent often manifests itself in subtle ways against students who are different. Students who are different become so sensitive that they detect persecution, when commiseration is really more the action taken. The problem is that people are not understanding each other's good intentions because they are so stressed.

The parapets we erect are not enough. This book is in part being offered to students prior to medical school to let them know it is "shitty" so they may be able to stand it better, as our student above stated.

What do you say to people who think you should be able to handle anything because you are a physician of a medical student?.

Decisions! Decisions!...what pills, if any, for this person? How to relieve the depression of that person? Who should be hired? How to make the budget stable? Then, at home at night, tired! A child asks for another decision. At least this answer can be observed more closely, to determine success or failure. Worry is in the back of your mind, gnawing at your soul.

You never know enough! I remember the story of the little boy who tried to put the ocean into a hole in the sand. A man, a great intellectual who was later made a saint came along, who told him "you can't put the ocean in that hole! As fast as you do the water drains out."

The little boy became an angel and replied, "Nor can you put all God's mysteries into your head. As you learn one truth, others elude you."

Medicine feels like so many of God's truths. As I think I understand one truth perfectly, another drains out for lack of understanding or use.

The positive aspects of medicine are touted, but need to be reiterated after all the negatives above. The feeling of a baby you delivered in your arms; the patient that gets better; or the smile of a child who says, "that's my doctor", these things offset the negatives. These are the reasons I stay in medicine.

CHAPTER IV

INDIAN WOMEN PIONEERS IN THE FIELD OF MEDICINE

The following two short biographies are of the first and second American Indian women to become physicians in the United States.

The first American Indian woman to become a physician was Susan LaFlesche-Picotte who completed her degree in 1889. Susan LaFlesche was born June 17, 1865, on the Omaha Reservation in northeastern Nebraska, the fifth and youngest child of Chief Joseph LaFlesche (Iron Eye) and Mary One Woman. According to Marion Marsh Brown [9]

> Susan LaFlesche was proud of her heritage. The LaFlesche name means "the Arrow" in French, and like an arrow that flies straight and true, and often far, to its mark. Susan's eventful life lead her far from the Omaha Indian Reservation in Nebraska that she called home. Her search for a way to serve her people brought her joy, sorrow, and great honor.
>
> Susan's endeavors took her first to boarding school in the East, where she and her sister became involved in all the work and fun that are so much a part of school. From there they both went to Hampton Institute, where Susan met a handsome young Indian, Thomas Ikinikapi. Susan and Thomas fell in love, but Susan's arrow had not yet reached its destination. Instead of marriage, she choose a career in medicine.
>
> Medical school was the most exciting place in the world to Susan. She studied hard and finished at the top of her class, the first American Indian woman to become a doctor. Her life was filled with challenges and hardships as she struggled to bring about a better day and a richer life for her people.

[9]Marsh Brown, Marion, Homeward The Arrow's Flight, Abingdon Press, 1980.

> After the death of her husband, Henry Picotte, Susan moved to the town of Walthill on the Omaha Reservation, where she estabilished a hospital in 1913. It was estimated that in twenty five years she had treated every member of the Omaha Tribe and saved the lives of many.[10] Dr. Susan died in 1915, after suffering for years from an extreme pain from an infection of the facial bones. Born in one culture, she became part of a far different one, but never lost touch with those who lived according to tribal values; fittingly, Presbyterian clergymen officiated at her funeral, but the closing prayer was made by an angel Indian in the Omaha language.[11]

Another remarkable Indian woman who became a physician at a time when women doctors were rare, and Indian physicians almost nonexistent, was Lillie Rosa Minoka Hill. Dr. Hill doctored among the Oneida Indians and their white neighbors for over forty years.

> Dr. Hill couldn't remember her own Mohawk Indian mother who died soon after giving birth on the St. Regis reservation in New York.[12] Joshua Allen, a Quaker doctor adopted Lillie Rosa when she was about five years old. Lillie Rosa wanted to become a nurse after graduation from high school, but her adopted father urged her to enter medical school, fearing that nursing, with its long hours and strenuous lifting, would be to much for her slight, five-foot two inch frame.[13]
>
> Lillie Rosa attended Women's Medical College in Pennsylvania and despite thoughts of quitting, graduated in 1899, the second American Indian women to do so. However, in 1905, Dr. Minoka Hill promised her husband she would give up medicine and raise a family.
>
> After her husband died suddenly of a ruptured appendix and peritonitis, Dr. Hill remained in Oneida and continued her work.
>
> At times she rode on the country snowplow through blizzards to reach sick families. She found them smeared with

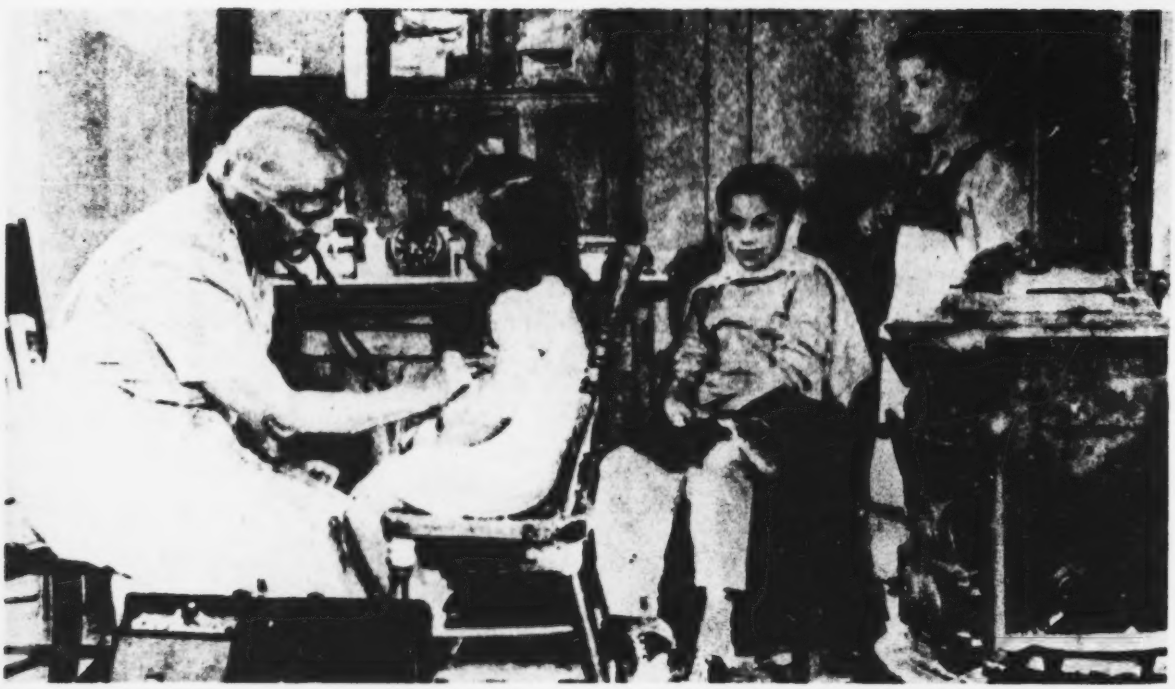
[10]Notable American Women, 1607-1950, Edward T. James, Belknap Press of Harvard University Press, 1971, p. 66

[11]Notable American Women 1607-1959, Edward T. James, Belknap Press of Harvard University Press, 1971, p. 66

[12]"The Kitchen Doctor" by Carolyn Haglund, New Month magazine, Green Bay, Wisconsin, February 1983.

[13]Ibid.

Photos are courtesy of Dr. Rosa Minoka-Hill Foundation



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Dr. Susan LaFlesche Picotte attended the Woman's Medical College from [illegible] 7, 1886 to March 14, 1889, when she received her degree. Dr. Susan LaFlesche Picotte, of Walthill, Nebr., died at [illegible] on September 18, [illegible] forty-nine years. She was the daughter of [illegible] LaFlesche or Iron Eye, the last of the great chiefs of the Omaha tribe. Her mother was Mary, daughter of Nikuma, princess of the Iowas. She devoted her life to the interests of her tribe, by whom she was [illegible]. She graduated from the Nebraska State Medical Society.

Photo courtesy of Nebraska State Historical Society

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bear grease or skunk oil and bundled in cotton batting. Dr. Hill never discredited home remedies or Indian medicines but prescribed more modern medicine saying, "use this too."[14]

Dr. Hill died on March 18, 1952 at the age of 76. She is remembered for the many times she helped others when they had little to give in return. Dr. Hill was a friend to all people and an outstanding Indian woman. She possessed a never ending supply of generosity, humanity and understanding.

What is evident in the biographies of both Dr. Susan LaFlesche-Picotte and Dr. Lillie Minoka Hill is their desire and motivation to help their people. Both could have moved to a city and set up lucrative practices. They instead returned to help Indian people, where they obtained a great sense of fulfillment.

Victoria Stevens M.D., San Carlos Apache should also be considered a modern Indian woman Pioneer in the field of medicine. She is an orthropedic surgeon. This is a tough field to get into for anyone, but especially an Indian woman. She was encouraged to pursue her career by an Indian student advisor at the University of Arizona. She found problems of a philosophical nature..."was in early 70's and organized medicine and medical school training seemed awfully irrelevant to the real world – almost quit my freshman year of medical school to do something else. College was fun, on the other hand."

She has suggestions on how women can prepare themselves for such a career –

Develop tunnel vision and place goal above all else. Seems cruel, but in order to compete it's really necessary, at least in surgery. The best advice I got in my training was to plan something as a career that I considered fun and enjoyable – would therefore advise a young person to choose a career the same way as choosing a good pair of shoes – looking for comfort, and the feeling that there is no pinching, squeezing tight feeling, that you could walk a long way and be very durable and energetic.

Also, it would have helped me to know that achieving a high goal can be a painful process, although if I had known beforehand, I probably wouldn't have tried to do what I did. (It may be that ignorance is bliss and overemphasizing the challenges may discourage students from trying.) At any rate, I was lucky to have a support system, and I advise students to find a strong figure or figures (like a group) and cling for dear life – unafraid to say "I'm scared" or "worried" or "terrified" – a place to let go and explore the weaknesses in oneself. I see Indian students painted into a corner – parents don't understand or want to hear the anxieties and worries. If

[14]Ibid.

you're in a competitive program, you can't let your teachers or fellow students know your problems (too embarrassing). So often, Indian students see themselves as supposed to be "perfect" to justify their grants, or to merit the praise or high expectations of their tribes, or their programs – and if a weakness is covered up, instead of exposed and repaired or reinforced, it can be fatal to the goal.

One reason I think I'm successful is that I've had plenty of non-Indian influences in my life that I'm not ashamed of -- grew up without realizing I was anything but myself -- lots of times students carry their Indian identity almost like guilt, as if to do anything non-Indian is that all goals must be directed to tribe or to the Indian sector. I like to tell your people they should feel free to join the mainstream -- go to Paris, live in Hawaii, New York, anywhere the heart desires. The most successful Indian professionals around cross all the boundaries -- they're people first, themselves, Indian second. Thanks for the opportunity to write!

Victoria M. Stevens, M.D., San Carlos Apache.

Johanna Clevenger, M.D., Navajo, can also be said to be a pioneer. Johanna was one of the fourteen founding members of the Association of American Indian Physicians in 1982. She was also the first woman president of that organization. Johanna was born in the Albuquerque Indian Hospital. Her mother, a full-blooded Navajo, was also a pioneer. She had attended college and taught school for many years. She motivated Johanna and until her death in 1985 was often seen at her daughter's side at meetings.

Johanna recalls racial prejudice while she was growing up. She and her mother frequently had difficulty being served in restaurants. Her father was non-Indian but a landlord asked them to move because the mother and daughter were Indian. She found less racial prejudice in college and medical school, although there was some discrimination against her because she was a woman.[15]

Johanna changed majors often in her undergraduate years. She married a geology instructor after her junior year. He died of leukemenia soon after their marriage. She decided to go on to medical school so went back and completed a medical degree. Her tribe helped her financially. While in medical school she married a fellow medical student. After graduation from Southwestern Medical School in Dallas, Johanna returned to Albuquerque to do an internship at the hospital where she was born. She and her husband worked for two years on the Navajo Reservation where they adopted a child, half Navajo and half Zia.

In 1967, Dr. Clevenger returned to Dallas and completed a residency in psychiatry. Dr. Clevenger considers the Indian Boarding School an important psychiatric issue. She feels that the boarding schools are harsh, militaristic, and repressive.

[15]American Indians Today : Vol. II, 1982, Beiswenger, Jim; pp. 18-19, University of North Dakota.

Indian children in boarding schools are liable to lose their ties with their tribal cultures. Dr. Clevenger believes that Indian children should be able to remain at home where they can learn traditional values and ways.[16]

Dr. Clevenger as president of the Association of American Indian Physicians worked hard to insure passage of legislation that would help young people have the opportunity to pursue health careers. She and others in that organization share a deep concern for the mental health needs of Indian physicians.

Catherine Kincaide was president of Association of American Indian Physicians in 1984 at that time a rap session was held concerning strenses the physicians were under. Johanna Clevenger lead the discussion. The rap session was important to the members and student members of the organization. Many groups of physicians have belabored the stresses of this profession. The results of those stresses, i.e., alcoholism and depression (to mention only the major problems) can be devastating to an Indian physician. This is even more so than to a non-Indian physician because the Indian world is so small and there are only about 240 Indian physicians. The expectations of the outside world for Indian physicians not to succeed adds more pressure to a person straddling two worlds, one with unreal expectations of its few bonifide professionals and the other fraught with malpractice suits and materialistic orientations. The rap session helped as did the more traditional healing ceremonies that were held later. Those traveling in two worlds need a double dose of help, one characteristic of each world.

Catherine Kincaide
President of AAIP

[16]Ibid, pp : 18-19.

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Catherine Kincaide, a Sioux from the East Coast is a member of a band that did not move westward with the other bands of Sioux. She is the second woman to be president of Association of American Indian Physicians. Catherine has worked hard for students and strongly supports the student organization. She gives freely of her time to talk to other Indian physicians that may be having problems. She presently lives in Santa Fe, New Mexico.

Some of the older Indian women physicians in AAIP would like more traditional activities during the annual meeting. The need for more spirituality was expressed during the rap session. The result was a sweat ceremony, one for men and one for women. This was held on the beautiful Fond du Lac reservation next to a cooling lake where people swam after the ceremony. The feeling of tranquility and refreshment was needed by the women who took part. They expressed a new closeness. The ceremonial parts of AAIP are developing and serving a greater good each year.

The cleansing rain in the middle of a desert on one trip from a sacred place where one ceremony was performed, was not just coincidence. The Great Spirit is also with those of us who must live in two worlds to be effective for either group.

Other Indian women physicians have been pioneers. Judy Wilson was the first Indian woman to graduate from the University of North Dakota with the first INMED class. She was a top student in her class and dispelled fears of UND faculty that Indians couldn't succeed in medicine.

Others such as Dr. Eva Smith, Shinacoch, and Dr. Lois Steele, Assiniboine, worked with students to get them into medical school before going themselves. Both of them work for Indian Health Service and have served on AAIP Board of Directors along with Deanne DeRoin and Vicky Stevens. If a person works for Indian Health Service they may not hold the office of president or treasurer in AAIP, due to conflict of interest.

I wish I could tell the stories of the many Community Health Representatives who are truly pioneers in medical care for Indian people. These people work on the front lines, taking medicine, patients and physicians over difficult roads in all types of weather. They are underpaid and usually not afforded the training they need and deserve. Their understanding of their own people usually gives them insights that a trained social worker from another culture will never have. They are subject to tribal political hassels and legislative acts they have no control of. Yet they serve! Perhaps a book can be developed to tell the stories of women like Ada White and others. A book that can capture the humor and paths of a difficult career.

INMED'S FIRST WOMAN PHYSICIAN

Judy Wilson, M.D., is a pioneer in her own right at the University of North Dakota
Entered medical school in 1973
Photo by Steve Lucas

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COOKS CONFERENCE
SEA WEED CLUB COOKERS
Doctors conference
Rm. 107

CHAPTER V

UNDERSTANDING AND RESISTING STEREOTYPES

Wednesday, October 17, 1984, at the University of North Dakota, Roberta Ferron, J.D., delivered a commentary on "Understanding and Resisting Stereotypes". She is equipped to deliver such an address as the outspoken Director of Affirmative Action Office at the University of Kansas. Ms. Ferron, 44, is a member of the Rosebud Sioux Tribe, South Dakota and the mother of four children (ages 23,22,21, and 20). She is a former special tribal judge at Crow Creek, South Dakota. In 1976, Ms. Ferron received her J.D. degree from the University of South Dakota Law School. She has held positions as Assistant Professor at Eastern Montana College and Montana State University. Ms. Ferron also taught art, business, and physical education classes to high school students at the Federal Way School District in Washington. She is an artist, and was a member of the Artist Co-op while living in Washington.

Stereotypes plague the Indian and medical worlds. Many of the people we serve have trouble distinguishing the harm stereotypes cause. The topic was chosen to strengthen students and staff in resisting the harm, and recognizing the problem stereotypes create. Ms. Ferron spoke of the subliminal indoctrination that occurs in the movies and television, that entices people to eat, drink beer, or do something else. The same indoctrination taught us in the 60's that doctors are white males, and in the 70's that women doctors do not have strong family lifes. These stereotypes do contain a type of truth! However, they dissuade our young Indian women from pursuing the highest health careers.

Ms. Ferron noted the depiction of Indian women in the advertisements of corn oil, yucca shampoo and margarine. These ads do not show our young women in modern roles. We are moving from an industrial to an informational society, Ms. Ferron cautions. In ten years we should know how to run a computer and in thirty years we should learn to speak Spanish to be current and efficient in our society, which should be bilingual by then, she predicts.

When it became popular to be "Indian", a number of Indian "values" were published in the new "Native American anthropology". These developed into stereotypes, such as the following, which were somewhat laughingly supplied by Ms. Ferron (with a couple additions).

(1) American Indians in general are described as "ecological", "stoic", and "brave", but "poor workers", "too motile", and "always late".

(2) The Sioux male is a "good lover", is "good looking", but "mean". He is often a "coyote", which implies cunning, and preying on helpless women. He is not easily caught.

(3) The A.I.M. (American Indian Movement) person stereotype evokes ideas of an off-reservation Indian who may be very good or very bad depending on who is the judge.

(4) Turtle Mountain Chippewa women are the prettiest in the Indian world.

(5) Navajo women dominate their men.

(6) Crow men are fun but strange.

What happens with all the intermarriage between tribes? Are any of the stereotypes real? The negative descriptions often arise from fear, which in turn generates anger. If a person is told repeatedly he/she is inferior; he/she will operate from a center of fear. This fear can cause anger or withdrawal. These two characteristics are often attributed to Indian people, especially by outsiders who work with Indian students or patients. If we understand why we develop such a pattern of behavior we can better cope. We should be actors, not reactors! We can act to determine our destiny; not just passively react to what happens by chance.

Ms. Ferron noted that a big blacklash movement against Native Americans in general is now occuring. She attributes this to people operating out of a center of fear. Lack of employment, tight money, rising deficits, and a threat of war make people afraid. It is easier to translate this fear into anger against people who are different, such as people of color. We are easier to identify. Affirmative action must be supported by people in power or the gains in equality made during the past fifteen years will quickly erode away. We must encourage people with all types of power to support affirmative action, although political power is historically the most important.

When we deal with our personal power, the key is to not give it away. The person who holds his/her temper, who shows patience and understanding, keeps his/her power. Yelling at your children, or letting your husband's innuendos make you defensive, takes your power away. It is easy to fall into stereotype positions when you are not in control. It is imperative to keep your personal power, being confrontive and assertive in your own person.

Ms. Ferron stressed that strength to resist stereotypes also comes from owning your feelings. "It really hurts me!", "It pisses me off!", "It makes me angry!", if it is your bent, you can be combative. If you are into power by intimidation, fight fair!

Don't pull one-upmanship tactics! The best way to combat stereotypes about Indians is to show that these stereotypes are not accurate. We must be seen in positive, self-enhancing roles. There is an Indian father that volunteers as a safety guard at a school crossing about one week every other month. I feel pride when I see him, even though I've never met the man. An Indian donating time to help all children across this busy highway is a positive role. This act can do much to erase the erroneous stereotypes within the majority culture of us not being socially responsible."

The ideas Ms. Ferron shared with her audience that night are a beginning to an examination of a crisis situation of identity and stereotypes that plagues our students. One traditional INMED Indian female medical student stated:

> "It's really hard for me to go to school because there are a lot of things I don't understand about the way people think. It is really different to be with your family and friends, and then to go back to a different group. I have a hard time trying to relate to them. The worst part was the cultural thing. The others (students) have this drive. There is something to drive me, too. Mine is my people."

> "I have heard from majority students many different price quotes as to how much a physician makes a year. They have that to push them. It's confusing at times to think that. It is just as important to me to go back to my people as it is for other students to make money."

Her ideas that all medical students are motivated by money is no more accurate than the idea that all American Indian women are admitted to medical school because they are a double minority, and not because they are qualified. Both stereotypes are inaccurate! Both stereotypes hurt our students! We stress at INMED that our students must meet the admission standards for medical and other professional schools. This fact is not generally stressed to the rest of the incoming medical student class. The majority students then use this inaccurate stereotype of unqualified minority women medical students as an excuse to look down on minority students, and to project some of their frustrations with medical school on those students of color. The reverse of our students characterizing others as money-grabbing, is also unfair. Cultural ideals of sharing and the extended family give money a different significance in the Indian world, traditionally. Value judgements on that significance occur and are hard for all to deal with. Explaining the differences is hard, and is as unfair to judge others' motivation for material things when the cultures are different.

Some stereotypes are supported by statistics. This can make a situation difficult. Participants of a session on Predictors of Performance of Male and Female Medical Students at the American Association of Medical Colleges 1984, Chicago, stated that twice as many black women dropped out as white males in their school and that it seemed that the women had a double jeopardy if they were minority. They noted that

the single best predictor of performance for the males was the MCAT* but that this was not true for the females. For the females, the only thing that the MCAT predicted accurately was how they would do no Part I and II of the Boards.** The best predictor overall for the females at the undergraduate level was their mothers' education. At the graduate level, i.e., residencies, the most accurate performance indicator for women, was their performance in internal medical or surgery. This group had used seventeen predictors. More information could be obtained from E. Virginia Calkins, Assistant Dean of Student Affairs, UMKC, School of Medicine, Kansas City, Missouri. Dr. Calkins concluded that male student performance can be predicted by cognitive data, and that the performance pretty well will fall within norms. Female students must be predicted on the non-cognitive factors and these are harder to put into norms. Interviews are much more important for female students and attention must be more carefully paid to these.

Dr. Paul Jollie talked about the success of men and women in medicine, noting that men have more upper ranks in medicine faculties, but that this may be due to the recent phenomenon of women graduating with these advance degrees. He did note that women have less research training and consequently are less apt to do research and this may also be a reason why they are not advancing as fast. He attributed differences due to personal or institutional as well as sexism differences but, noted that the individual's goals and agressiveness probably also play a role. Family, teaching and patient care are more important to women than advancement, secondary to research. The accuracy of this statement would be true for the Indian women that I know, that have gone through medical school. Reservation Indian women would fall into this category much more than a woman with a lot of urban non-Indian influence. The importance of mentors to women in medicine was raised by Dr. Jollie and we have discussed this elsewhere in this book. It comes up over and over again; "Where are the women that are going to help the other women up the ladder?"

Another stereotype related to isolation of women in medicine would be directly applicable to Indian women in the field. Studies indicate that the suicide rate for women M.D.'s was much higher than it was for the male M.D.'s and for women in other professions. Isolation has been blamed for this. There is a great paradox between the number of women in the field and the amount of isolation that is still there and that even though more women are entering medicine, the isolation problem is not being solved. This may be due to some pressure from personal goals toward career achievement that negates work toward personal pursuits. Any women that puts her personal family situations above her career will become suspect to those that are going

*Medical College Admission Test: a standardized examination used by medical school admissions committees to help determine qualifications of an applicant.

**Boards: National Board Exams are given at various stages of medical education to determine whether a person has mastered the material. State licensure depends on the passing of these exams in most states of the nation.

strictly for a career. Both groups of women are caught in a dilemma to which there seems to be no solution at the present time. Literature documents (Carol Gillihan and Jean Black) that women seem to value and to need a relationship with other people more than males do. This may be biological more than social. It is well studied that there is a difference in the character of involvement of a relationship between women and similar relationships between men. The medical training system does not value and support interpersonal relationships. This brings about a very isolating situation for both men and women. Indian communities need to be made aware of this so they can provide support and friendship to the physician, instead of contributing to this isolation and stereotyping an Indian women physician as "a woman who needs no one."

The important focus of this chapter is the realization that stereotyping helps bring about the loneliness our women suffer while obtaining a professional degree. How much damage is done by the erroneous ideas people hold; ideas that tend to erect barriers to open communication and friendship?

DEFINITION OF A GOOD INDIAN WOMAN

CHAPTER VI

THE DEFINITION OF A GOOD INDIAN WOMEN

The stereotype that can be the most destructive for Indian women pursuing the highest health careers is often a stereotype fostered by their own families and friends. The definition of a "good Indian woman" should be positive, and developed by each women to fit her needs. However, as David Reisiman, author of the LONELY CROWD, pointed out years ago, the tribally-directed part of our personality accepts some roles with little question. The definition of a female in the group has often been the role questioned least often, until recently.

Nearly two years ago, the idea of having a panel of "experts" discuss stereotypes and define a "good Indian women" crossed my mind. The women students in attendance might feel more comfortable having such "experts" voice questions and answers they found too painful or threatening to cope with in a group counseling session. This grappling with identity can be a crisis for women from age ten to thirty. Aging in this society which accents youth and beauty can bring about another type of crisis after age thirty. The stereotypes have at times paralyzed some of our women. Through the panel we endeavored to examine ideas and replace any inhibiting definition of good Indian women with permissive, positive ones.

From left to right: Juanita Helphrey, Cindy Linquist-Smith, Roberta Ferron, Lois Steele, M.D., Art Raymond, Twila Martin Kekahbah.

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The whole panel was first requested to "write down three words that describe you! Is this your ideal or do you live this definition?"

The panel included two INMED Advisory Board Members, Twila Martin-Kekahbah, Turtle Mountain Chippewa Tribe and Cynthia Lindquist Smith, Devils Lake Sioux. The panel also included Art Raymond, Rosebud Sioux Tribe, a former North Dakota state representative and currently a university faculty member; Juanita Helphrey, Executive Director of the North Dakota Indian Affairs Commission and a member of the Three Affiliated Tribes of Fort Berthold Reservation; Roberta Ferron, J.D., Rosebud Sioux Tribe; and myself, Lois Steele, M.D., Fort Peck Assiniboine.

Robbie, who is director of the Affirmative Action Office at the University of Kansas, discussed the steps that lead her to law school. She had to resist stereotyping herself in order to succeed. She told the audience that women must develop your skills and abilities; strengthening your personality with integrity is important. She spoke of the necessity of developing a "helping personal power," Sharing and togetherness are important.

Juanita Helphrey stated that "leadership really is learning 'how to develop trust' ". Her definition of "good Indian woman" included:

GRANDMOTHER – one who comforts, accepts, struggles and helps others cope. SISTER – A friend who loves unendingly. This person is the extension from grandmother to mother. She is the one who matures dreams.

Juanita, who is the first women to ever serve as Executive Director of the North Dakota Indian Affairs Commission, feels that the thing most desperately needed is the support of one woman for another. Too often we do not help each other enough.

Twila Martin-Kekahbah, watched INMED grow and was the first to speak of the necessity for a Women's Educational Equity Act grant to help the female students. She gave the audience an inspiring account of her own quest for a Kellogg Fellowship. She urged others to develop the confidence necessary to try for such honors. She noted that Indian people must develop self-reliance without federal programs. We must develop leaders. She asked the audience to think of what qualities leaders possess. She was asked (in her Kellogg Fellowship interview) to name three leaders, and the one person in the world she would most like to have lunch with. Her answer to these same questions helped net her the position as one of 43 people, out of 900 applicants, to be selected for the Kellogg Fellowship.

The audience seemed to feel that the characteristics of an effective leader – and a "good Indian women" – are: self dicipline, a person who plans efforts, moves on her own initiative without being told what to do, a person who can set objectives and then move on them. Twila stressed the importance of self-reliance.

Cindy Lindquist Smith, tribal health planner for her own Devils Lake Sioux Tribe, had asked older women of her tribe for their definition of "good Indian women". The answers varied, "One who remembers her traditions and takes care of her family;" "One who remembers who she is inside;" "She takes time to remember but doesn't circum to anger and fear;" "One who remembers, what comes around, goes around;" "a person with self-respect so she can respect others".

Art Raymond had helped to write INMED's first Women's Education Equity Act Grant, and he understood the reasons for the panel. He told of board school experiences and the indelible marks they left. The original I.D. number that was stamped on the children entering Indian boarding schools has faded, but the experiences, bad and good, have stayed. Art said, age and spirit--all are equal. It matters not from where you come, different talents should be shared, because the Great Spirit made it so. Art's mother died when he was 14 years old. "I would have been very dependent on her but her death forced me to grow," he said.

His implications of the dependence of Indian males on their mothers and grandmothers fits in with the admonishment of grandmothers mentioned previously, to be "gentle to our men, as they are fragile."

A man's strengths are wrapped up in this fragility that the grandmothers see and handle best. Art did not say how old a "grandmother"must be. Maturity is a good trait, and one not easily achieved. Age alone is not synomous with maturity.

Robbie Ferron added comments concerning the discrepency between the agenda of women of color, and that of majority women. We need "sisters" to support us. We need to discuss those differing agendas. She spoke of the need for swing sets in retirement homes although it is now against the law to take grandchildren in. The important role of Indian grandmothers in raising and teaching young ones in the Indian culture shows such laws are absurd.

I have not incorporated my remarks from that evening. It is hard to talk and take notes. Actually this book is an extension of my feelings and ideas on the matter, many of which were raised as we attempted to define a "good Indian woman."

Juanita wrote the following poem on her way to Grand Forks that evening.

DEFINITION OF A GOOD INDIAN WOMAN

WHAT IS A GOOD INDIAN WOMAN TO ME?
A Grandmother who comforts so lovingly,
Who accepts all my friends the way that they are,
and seems always there no matter how far.
She's wise in the ways of all humankind,
and raises her children,
their own destiny to find.

My Grandmother's struggles and burdens were many,
for she was only a child at the turn of the century.
She saw all the changes occur to her people
and her attempts to withstand them at times seemed feeble.
Her insight and foresight and faith in the Great Mystery
kept all hopes bound in a dream of preserving our history.
She pieced life together with comfort and hope
and mended and sewed so that others could cope.
Many dreams were destroyed in that turn of the century,
but my Grandmother pushed on
for her children
and their destiny.

WHAT IS A GOOD INDIAN WOMAN TO ME?
A child of that Grandmother, the Mother of me,
Who continues the pursuit and the dreams of her Mother
and raises her children
to be like no other.
Yes, there were struggles and burdens as life does provide,
but her hope and her faith (like her Mother's) did not subside.
"There's a special place in this life for us all" is her theme
Where you can grow to be you
with the help of your dream.
So with what little she had and with help from but few,
she raised her family with goals to pursue.
We've stumbled and fell many times in our growing,
but her mending continues
and her faith keeps on flowing.

WHAT IS A GOOD INDIAN WOMAN TO ME?
A Sister - I'm lucky to have three,
Who are friends who love
unerringly.
My Mother raised us all in the same manner
But we are different
and rightly so,
Because my Mother, and her Mother, gave us this right
and this way
to grow.
A Sister is an extension from Grandother to Mother
She carries on traditions
and keeps family together.
A Sister has family ties so strong,
that her Cousins and Aunties
are Sisters and Moms.
A Sister shares parts of the pursuit of our goals
She nurtures the dreams of our Grandmothers
and mends them as they grow.
A Sister gives life and the family grows on,
piecing and mending life
with each new dawn
With comfort and hope and gifts from our Grandmothers
to make this a world we can live with others.

WHAT IS A GOOD INDIAN WOMAN TO ME?
All the Women in my family and myself,
a handmended product of all before me
and all of you and your circle.

Juanita J. Helphrey
Hidatsa-Three Affiliated Tribes

A "Good Indian Medicine woman may win first place in a special fancy dance contest at United Tribes Training Center, such as Linda Gourneau did above.

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A "Good" Indian woman can play hard and work hard. She works with the team and helps others to get clear to score.

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A "Good" Indian Woman often has to risk despite odds to achieve much for others.

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Deb Wilson-Ft.Berthold
INMED Counselor

A "Good" Indian woman knows how to swing hard when necessary to help her people!!!

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A Tribute

Physician Henrietta Blueye (Seneca) 35, died earlier this year after a lengthy bout with cancer. Dr. Blueye grew up on the Tonawand Reservation, Basom, N.Y. A graduate of Radcliffe College, Boston, Mass., she received a medical degree from University of Washington at Seattle in 1976.

Reader Judith Salmon Kaur, M.D. wrote recently to say, "I did not know Henrietta well, but in our brief encounters at the Association of American Indian Physician meetings, I found her engaging, brilliant and vibrant . . . Please do not forget to remind others of her courage."

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CHAPTER VII

STRESSES ENCOUNTERED BY AMERICAN INDIAN WOMEN

By Phyllis Old Dog Cross

Presented during Indian Time-Out at the University of North Dakota
April 20, 1979

I have been asked to speak here today on stress with special emphasis on stresses encountered by American Indian women. From almost every paper one picks up today, or magazines or even books, one can see that stress is of great concern to the American public. I am going to talk a little bit about these various stresses, talk a little bit about what to do about it and talk some about the unique aspects of stress on Indian people and Indian women.

The first thing that's important for you all to know is that stress is normal. In my opinion, stress is good. What we need to discuss are two things; that is, the quality of the stress and the quantity. What do I mean by stress being normal? If we didn't have stress–physical, mental and spiritual–we would probably be one giant blob. Stress is what makes us human beings, and not only human but also the quality of humans that we are. In our great search for happiness it is necessary that we have stress. But let's talk more about that.

If one works in mental health for very long and learns the peculiar language that we mental healthers use, one soon learns that you have to declare yourself, very similar to the way the general public which must declare itself Democrat or Republican, Lutheran or Catholic, for ERA or against ERA, and so forth. I happen to be of holistic orientation. This orientation to me is the one that Indian people can live with, and offers the theory that one cannot separate the body from the mind, from the spiritual aspects of the person. We are one in totality, and that one cannot separate mental illness from physical illness or even spiritual illness. Our current medical models tend to emphasize that mental illness is unique and different from physical illness. This I will discuss a little later in my talk.

Persons that have worked in this field define stress as reactions of people to problems of living. I tend to be oriented along the concepts of daily situations people encounter in living. Just for fun, I've tried to figure out when the first human experienced stress. First, I thought perhaps it was when Adam and Eve were thrown out of the garden of Eden, certainly that was a great stress, the loss of paradise. Then I thought

perhaps Adam was the one that suffered a first stress when he got lonely and God put him to sleep and took a rib and introduced him to Eve. Adam's loneliness was stressful and I would suspect that some of the males in the audience might feel the introduction of woman to man would also be stress provoking. I even think Eve was stressed when the snake crawled up and tempted her with the apple of knowledge, and all of us know what happened after that.

I have thought about this quite a bit and I feel that there are cultural differences in the stress that people encounter, and cultural differences in reaction to that stress. By that I mean that Indian people and Indian women suffer unique stresses, stresses that a brown skin brings to us, stresses as a result of conflict of cultural values, and stresses as a result of oppression. Ron Lewis says that, contrary to the popular belief of I'm O.K., you're O.K., that it's not O.K. to be an Indian. American Indian women in my opinion suffer dual or even triple stresses. That is, they suffer the stresses all women do, that of sexism, and oppression as a woman. Being a liberated woman in today's society certainly produces unique stresses. Also being an Indian person in today's society is extremely stressful the lack of equal opportunity, the lack of equal alternatives and equal accessability to all sorts of services. Racism and prejudice and extreme poverty are stressful situations for the average Indian person.

I have spent most of my working life concerned with equal rights for women, and also equal rights for Indian people. The opportunities for women, much less Indian women, in the United States today, are very few. The lack of opportunity in the employment field or in any position of power or political field is obvious for women. The lack of equal pay for women has always been appalling to me. Even though a woman is educated, has experience and is fully competent, she finds herself relegated to lesser positions in favor of the male. In the woman's search for security, she has been willing to compromise herself to a role of dependency, and I think sometimes a role of child-like behavior and sometimes idiocy. As a result she has paid a terrible price. In a recent survey of people in the United States, a study was done to see who was happier, males or females, or perhaps a better way to put it would be to see who was more satisfied with their life situations. The first on the scale, or the most happy, is the married man, the second on the scale of those most happy is the single woman, the next most happy or third in the line is the married woman and the least happy is the single man. Need I say more?

Women in the United States have evolved from the strong frontierswoman or pioneer to a woman who is relegated to a very lesser role of staying at home, and depending upon her husband for status. Female children are taught from youth to be dependent and passive. Girls have been taught that they must behave and look in certain ways to be attractive to the male.

Women are expected to be model mothers, model wives and model students, and to work twice as hard at their job in order to earn less than their male counterpart. I have known women, and it's not unusual, who are married, have young children, hold a job, may even be going to school part-time, and manage to keep all this going without help from a husband who sometimes resents his wife and offers complaints, and they

wonder why they're going nuts. I am reminded of the song sung by one of the country western persons who says "I'm acting crazy to keep from going insane."

Indian women, I feel, have the unique stresses, and if non-Indians suffer stress, I think Indian women probably would multiply that times five. I usually feel it is a situation which I term the "Indian princess" versus the "woman warrior" role. Indian women tend to succeed more and are more tenacious in their search for personal integrity than Indian males. Yet they are looked to to be the strong ones in the family situations. In their competition to find a mate, they find themselves competing with non-Indian women who view Indian males as highly desirable. Families of Indian woman sometimes are not too supportive of women in their search for personal freedom and personal success. Even Indian women are not supportive of one another. While we should all be sisters in our struggle, we sometimes find our own kind to be critical of us, yet I think in Indian life, the Indian woman is much stronger in the political arena, and in the leadership arena, than her white sisters are. I think the main stresses Indian women suffer result from racial, cultural and spiritual conflicts; conflicts not experienced by non-Indian woman.

I'm sure all of you know what experts are... people that go to school, become an expert in something, and then insist that they are the only one's that can speak on the subject; and spend a great deal of time insuring that others do not assume this perogative. Experts in the field of stress have developed what's called stress scales. I brought some with me today to give to you.

Various problems encountered in daily living situations are listed and given a number value. Certain stresses such as a death, or a divorce, or a loss of job probably "rate" higher than other stresses such as holidays or promotions. I have been working on what I call an Indian stress scale, or trying to develop a stress scale for Indian people that's unique to their culture.

Stresses can be interpreted to be any change, physical or emotional. These stresses include anything that deviates from what might be the norm, and are both positive and negative. All of you know that any little change in routine throws us off. We tend to be more comfortable when things go in a orderly manner, as we planned, and as we are used to having them happen to us. Just think of our emotional reaction if we oversleep, or if we spill something on a dress that we intended to wear, or if a road that we normally take is blocked, or if some store we usually go to is closed, or if our dress isn't ready at the cleaners, or that we are out of sugar, coffee or our favorite breakfast food. We all develop little patterns, we put our right leg in our pants first, a certain shoe on first, we brush our teeth before we do this or that. We are comfortable with routine, and yet paradoxically, even routine hum drum routine, sameness, can be stressful.

The major stresses one encounters in life are the losses, deep personal losses; losses of people through death, through divorce, through moving, through graduation of children or rejection.

Other losses include; loss of power, status, prestige and self-esteem. These include loss of job, loss of personal possessions, loss after a fire or robbery, or other losses such

as loss of physical beauty, loss of sexual achievement, loss of parts of our body such as a woman experiences after a mastectomy, loss of teeth, hair, eyesight and other things that indicate we are a whole person. Other great changes occur when we change jobs, when we move, when a family member marries, graduates or has a baby.

Strangely enough, life changes that should be considered positive are often the most stressful, and may even result in depression and suicide. These changes include promotions, marriage, graduation, honors of some sort or another, holidays and other celebrations. Most of you have read of cases where persons had severe accidents or committed suicide upon graduation from college or medical school, or after a promotion. Most family fights occur during gatherings, including weddings and funerals. Those times which are considered to be most joyful for family also produce the most anxiety and violent reactions.

So what does this all mean? In the beginning of my talk I said that stress is good. The thing to recognize, and this is very difficult for most persons because we are all so used to seeing ourselves as having things caused to us, as things being laid on us, as people harassing us; the first step any person can learn in dealing with stress is to realize that reactions to stress come within us; from our insides, not from the outside. Only we, ourselves, stress ourselves, others cannot stress us. All of you think of a time when you were extremely upset, angry, and bitter, trying to think of ways to get even, and recognized that this stress came from within. That person you wanted to blame had nothing to do with it, it was merely your reaction.

Perhaps I should mention here some of the symptoms of stress. The most common symptom is the feeling of being under pressure, feeling anxious, feeling as if you're going to fly apart. Your muscles may be tense and feel stiff, you may suffer headaches, you may feel tired and complain a lot of feeling fatigue. You may suffer insomnia, most frequently a type of insomnia related to feeling so tired you fall asleep easily but wake up at one or two oclock in the morning and then aren't able to fall asleep again, and repeating that pattern. You may feel restless, you can't keep your attention on one thing, you may feel irritable. You'll notice you're dropping things, you may complain of feeling depressed, feeling down, feeling low; you may complain of your heart beating too fast or having a catch in your throat. Some people even complain of dizziness, stomach upsets, constipation or diarrhea. Your body and physical appearance reacts. Your skin may look bad, you may complain of itching, your hair will look dull and may even fall out. You may feel chronically angry or upset, you'll find yourself eating too much, drinking too much or indulging in other excesses. In general, there's a vague feeling of dissatisfaction, pressure and unhappiness. In holistic terms, you are out of tune with life, your harmony is destroyed.

Many experts now, people in the field, are convinced that physical symptoms are directly related to stress. Most of you know that when you are under a lot of pressure or depressed you will get colds and flu more easily. Some persons feel that having a cold is a first symptom of stress. Backaches, and low back pain are symptomatic of feeling caught in a situation; arthritis, and arthritis pain indicate anger and hostility that one cannot release. Dermatitis indicates a dissatisfaction and feeling under pressure with things that one cannot cope and deal with.

Ulcers and bleeding ulcers usually indicate a life situation in which one wishes to escape, and is described by some psychiatrists as a slow form of suicide. Colitis and ulcerative cholititis indicate being in a life situation one wishes to escape, but cannot. Migraine headaches and chronic asthma also indicate a life stress situation which a person cannot cope with.

Studies have shown recently that certain types of personalities are prone to cancer; cancer victims are usually described as happy, easy going, non-conflicted individuals. All of us have heard of type A personalities. The kind that works under pressure well, always pushing, striving, but an ideal candidate for myocardial infarctions. So, while we all run down our peculiar symptoms to find out what our stress is and how we're dealing with it, we will now move in to the final part of my talk on stress and how to deal with it.

Earlier I said it was important to realize that we ourselves cause our own stress. Another way we can deal with stress is to realize that most problems are not as serious as we make them out to be. A good way to deal with this, when you worry about something, is to visualize the worst thing that can happen and what you will do? Another way we stress ourselves is by worrying about the past, if we can realize the past is done and over with--it is history, no matter what we do about a thing, it is done with; we are never going to repair it, we might as well see that it is finished and not ruminate, regret or go over and over again what has been done. Another area not often discussed, but where we all get ourselves into trouble, is the area of somehow having to prove we are right. Most of our conflicts with others are in the area of trying to make the other person see how right we are, and how wrong they are. If we can come to some resolution within ourselves to see that being right is not very important, and that letting another person be right is really inconsequential to ourselves, we will certainly find peace. Another area of stress is chronic procrastination, with the result of feeling that about a dozen things are piled up and we have to get them all done. One of the most stress-relieving things to do, when you feel under pressure, is to chose that thing which is stressing you the most and do something about it that day. You don't have to solve it, but you can at least start to work on it. Perhaps it has something to do with budget, maybe cleaning the house, it may be making an unpleasant phone call regarding a bill or some problem; do something about it, don't put it off. Some people have found it helpful to make lists, choose one thing from that list and do something on it, ignore the rest. Even making lists helps the stress.

And most of all, realize that most problems are not as big as you make them out to be. Look at those things you worry about and see what you can actually do about the problems. Sometimes you worry a great deal over things you have no control over, so why worry about it? It is very important that you do not take yourself too seriously, and that you do things physical that are good for you. This can include walking, running, swimming or other kinds of activities. It is important, I think especially for Indian people, to get out doors and commune with nature. Other techniques are relaxation techniques, yoga, biofeedback, personal network development, hobby, and self-hyponosis or meditation, which are all extremely helpful in relieving stress. It is important to be aware that the mind can heal the body as well as kill it. But conversely, the body can heal the mind. And to finish off, I am going to read a poem. It's an anonymous poem and it's one that I get a great deal of pleasure out of. It goes like this:

If I had my life to live over,
I'd try to make more mistakes next time.
I would relax, I would limber up,
I would be sillier than I have been this trip,
I know of very few things I would take seriously,
I would be crazier, I would be less hygenic,
I would climb more mountains, swim more rivers
and watch more sunsets.
I would eat more ice-cream and less beans,
I would have more actual troubles and fewer imaginary ones,

OH, I've had my moments and if I had to do it over again
I would have more of them,
in fact I'd try to have nothing else,
just moments one after another,
instead of living so many years ahead each day.
If I had to do it over again
I would go places and do things
and travel lighter than I have.
I would start barefooted earlier in the spring
and stay that way later in the fall.
I would play hockey more,
I wouldn't make such good grades except by accident,
I would ride on more merry-go-rounds
and I would pick more daisies.

Submitted by
Phyllis Old Dog Cross - 1979

HOW HUSBANDS COPE

CHAPTER VIII

HOW FAMILIES COPE

The information up to this point deals with the trials and tribulations of American Indian women health professionals. Pursuing a health career is a demanding, sometimes difficult task, not only for the student, but also for her family (i.e., spouse, children). One of the activities held through the Wein Was'te Program (WEEA) was periodic rap sessions for the spouses of medical students. These sessions were informal and offered the spouses a chance to network support with other medical student spouses. An advantage for the spouses, was that Lois Steele, M.D. lead the discussions. Dr. Steele was able to offer a former medical student's point of view. She tried to explain some of the pressures and experiences medical students face.

Other medical students often times have the notion that Indian students were admitted to medical school just because they are a minority. Minority medical students are often put into situations where they must work extra hard to prove themselves.

Another emotional burden that prevails among medical students stems from the competitiveness that exists, in all areas. Competitiveness is usually not a characteristic of more traditional Native Americans. The stresses minority medical students deal with are difficult, and can be devastating. During the rap sessions, these concepts were shared with spouses, to help them cope better with the stresses of their medical students. The rap sessions also afforded the participants an opportunity to discuss problems among themselves, which led to a feeling of sharing and some emotional reinforcement. Listed below are some of the medical student spouses' common concerns expressed at the rap sessions, with the solutions offered :

CONCERN:	He/she spends a lot of time studying and I'm feeling rejected (lonley).
POSSIBLE SOLUTION:	It is the quality, and not the quantity of time together that is important. Set aside certain time/day for each other and and/or children, (i.e., Friday nights, Sunday afternoons). Find a place to be completely alone, (i.e., a motel room borrow a friend's cabin, etc.).
CONCERN:	He/she is really tense during block exams, how should I handle this?

POSSIBLE SOLUTION: Try to make the student as comfortable as possible. Unplug the television and telephone if this helps. Pursue a hobby or outside interests, (i.e., sewing, reading, visiting friends), and when it comes to exams, be understanding towards your mate, tell him/her how wonderful they are.

CONCERN: I do not like to have to make all the decisions regarding the home and/or children, how should I handle this?

POSSIBLE SOLUTIONS: Try to handle the minor decisions on your own; again scheduling is important here. Set aside a certain time for discussing bills, the children (if applicable) and other home decisions. Another possible solution would be to make a decision, and then check with your spouse for their input on your solution or decision.

The main thing to remember is that communication is very important. Communication accomadations must be established well during the first two years of medical school, as the clinical and residency years are even more time-demanding. Unplugging the telephone and television may enable you to communicate better by eliminating distractions. Be as understanding as possible, but try to obtain enough attention from your spouse when you need it to prevent problems from becoming larger ones.

Bill and Linda Gourneau have been married for ten years. Bill is a member of the Turtle Mountain Chippewa Tribe, and Linda is a member of the Three Affiliated Tribes of the Fort Berthold Reservation, she is a third year medical student. In interviewing Bill, it is evident that family is very important to him. According to Bill, Linda spends a lot of hours studying, however, she does most of her studying at home. Bill and their son, Brendan, try to cooperate with her by creating a relaxed atmosphere for her at home. When asked what was the hardest part of being the spouse of a medical student, Bill stated that spending a lot of time alone is difficult. He goes on to say that to him, it is the quality–and not the quantity–of time that they spend together that is important to him. In the summer, time spent together might be at a wacipi (pow-wow), where the whole family participates. Bill sings with the Red Nation drum from the Devils Lake Sioux Reservation, Linda is an excellent fancy dancer, and son Brendan is a boys'traditional dancer. Brendan, by the way, can also break dance.

Household tasks are something that Bill stated he does not really care for, however, he realizes that his wife's medical school is a much harder task. Bill noted that having a career helps him to feel useful. Bill holds a bachelor of science degree in education and also a bachelor of arts degree. He is presently the Research Analyst at the INMED Program. When Bill was temporarily unemployed, he said the household tasks seemed menial, and it was tough for him. He further explained that he felt he did not want to be a "house husband"; adding that although he sees nothing wrong with the concept of "house husband", society does not really know how to deal with this. He said his peers will joke around about him doing dishes, however, this doesn't bother him, because humor and joking is part of his culture. He also emphasizes that Linda does much of the housework, despite his willingness to help.

For Bill, there are some positive aspects of being the spouse of a medical student. For one thing, he and his son Brendan are very close and spend much time together. He added that it is naturally nicer to have the whole family together during times when Linda is free. Another positive aspect is that he has a close network of friends who provide him with support. He feels that Indian women do not usually compete with their spouses, or act intellectually superior to their husbands. He adds however that this is based on his own opinion and experiences.

"Communicating is most important to effectively handling the situations that arise," Bill commented. "By making a sincere effort to communicate, you will be able to work out the problems. Something equally important is that both spouses must feel secure." Bill noted that the fact that Linda and he have been married 10 years is a plus. "For the newly married couple, medical school would probably be more stressful, if that is possible," Bill stated. When asked if he had any comments for other husbands of medicals students, he said, "Communicating is very important. It is a tough experience, but winable."

WIRY HUSBAND WITH HIS SISTER

A wiry man sits with guitar in hand singing the words of a John Denver song:

"There's a storm across the valley and the clouds are rolling in..."
"It's the simple things that make the home.
The fire is softly burning,
supper's on the stove,
this here's the story of a house husband,"

He goes on adapting the words and music to his own situation. His wife is in her first years of residency and at the top of her class. They have been together since she was a college freshman. He has a B.A. degree and is now doing graudate work. He is visibly proud of his wife. His family is visibly proud of his sacrifices, and of his support of her effort.

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He laughingly tells a story of how he gave a presentation on being a house husband. He tried to describe some serious aspects, but somehow his sense of humor came through and the audience roared. The ability to laugh at oneself has been a major factor in enabling husbands of our medical students to survive.

Another husband of a medical student talks of the sharing he and his wife do. His wife is a fourth-year medical student. In that relationship, it seems that the sum of their contributions adds up to more than each could give individually. He also has the ability to laugh at himself.

The common characteristic of these three marriages is that all the husbands are also Indian, and all three couples have children, some of whom were born before the wife started medical school. The understanding, maturity, and sense of humor evident in these men may be the common elements necessary for a man to point with pride and say, "My wife is a doctor."

My mother is a Doctor

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OUR CHILDREN
by Twila Martin Kekahbah

The future of American Indian Tribal groups lie with our children. Unfortunately our fear of losing tribal ways combined with our need to co-exist with non-tribal people makes a heavy burden for our children's future. On one hand we tell them to follow tribal traditions, on the other, we allow the values and morals of the dominate society to set the tone for the day. For example, statistics have proven, as we know from our own observations, children who are parented by television sets, role model the characters they admire. The problem is most of the television characters are not admirable as role models for any child, let alone Indian children.

All children are born with: (A) the power to be capable human beings, and (B) an environment which has the potential to develop them to their fullest. As Indian parents, or potential parents, we must concern ourselves with the development of life coping skills for our children which will assist them in becoming capable Indian adults. The differences our parents faced as children from those which we faced as children are monumental in terms of change. One of these changes, the breakdown of the extended family, is a negative factor in determining our children's future. However, we are fortunate we are only one generation removed from this change. This breakdown of the extended family unit can be compared through family interaction time for one given year versus another year a decade or two later. Although I don't have data to prove this supposition, I have participated in many discussions with American Indians raised during the 50's and 60's, and have heard them tell of the ways in which they were raised as children, compared to their own child rearing practices. My conclusion is firm, there have been major changes within tribal family structures. For example divorce rates have increased steadily year after year, tribes with little or no divorces issued in the early 60's are now handling two or more per month.[1] In addition we are experiencing higher rates of child abuse, spouse abuse, desertion, neglect, elderly abuse and use of controlled substances.[2]

Prior to the mid-70's, the extended family consisted of parents, children, grandparents, uncles, aunts, cousins, etc., most of whom lived nearby. Within the

[1]OVERSIGHT OF THE INDIAN CHILD WELFARE ACT OF 1978; Hearing before the Select Senate Committee on Indian Affairs, United States Senate, April 25, 1984.

[2]Ibid

family there was a lot of interation: children improvised games; grandparents were the center of activities, parents got together and discussed items of interest, work and play were shared. With the advent of more educational opportunities, economic changes in the Indian communities, more available HUD-type housing, retirement complexes, greater mobility, etc., we say, for the most part, the extended family changed to a nuclear family. The nuclear family consists of one or two parents and the children, where interaction time between the parent and child has been greatly reduced. Grandparents, uncles, aunts, cousins, etc., either live too far away or everyone became too involved in their own day-to-day activities with little time to reinforce the extended family structure, so there are many children being left without any form of positive guidance. In fact, the discussions I had with parents, seven out of ten indicated having negative communication with their children during the times they did communicate. Factors leading to the negative communicating includes single family households, use of controlled substances abusively by one or both parents, stress created by demanding work load, i.e., school or job and lastly, an undisciplined child. All of this is not to say the nuclear family can not exist if the child is to develop capably nor, is it to say the nuclear family can not exist if tribal ways are to be maintained but, as American Indians we must be aware of what all this means for the future of our people.

Our life styles have changed so rapidly over the last couple of decades, we are now beginning to see the negative aspects along with the positive, caused by such a rapid change. It would be as ludicrous to believe we can recapture the old ways as it would be to believe we can't control the new ways. All we need to plan our future is to think about what we want for our children, the beauty in this form of planning, is the flexibility. We can think about the future of our children before we have them, this being the most advisable form of planning, or, we can think about their future while they are still with us or, we can think about their future through our grandchildren. At the very least, we must question the future for our children and determine what it is we want for them.

At some point in time we will decide what basic skills and attitudes we will want our children to possess. Some of these skills and attitudes might include the following considerations.

1. Role models who are considerate, productive and self-sufficient. In early stages children will emulate those closest to them, so our actions should depict positive images. In helping our children establish positive role models in the beginning, they will develop as strong, capable individuals with a desire to be around others more like themselves.

2. Sense of family, which results from being taken seriously as an individual, is another skill needed in development. In her book, I...RIGOBERTA MENCHU, AN INDIAN WOMAN IN GUATEMALA,[3] tells how a child is talked to from

[3]I...RIGOBERTA MENCHU, AN INDIAN WOMAN IN GUATEMAL, edited by Eliabeth Burgo-Debray, translated by Ann Wright, the Thetford Press, Ltd., Thetford, Norfolk, 1984

the first day of the mother's pregnancy. She goes on to say, a child is taught to share from the moment he is able to grasp the concept, for without sharing, the community would dissolve.

From this concept created by the family there emerges an attitude of sharing and caring for others. One of the differing factors in my discussions with Indian parents raised prior to mid-70's versus what exist now, was the significant contribution children made to the overall economic stability to the family. Whether it was picking berries or chopping wood, children knew they were needed, and the time spent with family members in completing such chores also made them sure of being wanted as well.

3. The ability to look into oneself is another skill needed to develop as a capable person. A time to dream, to do battle in one's mind, good versus evil, right versus wrong, are all subjects which need to be explored in self-development. A child who is encouraged to know himself is less likely to come under the influence of peer pressure. In this effort we must be cautious to not use unnatural stimuli in promoting a child's development. To request a child to think about one's self than to be left alone with a television, radio, walk-man or video games is not the way to develop capable young adults.

A more meaningful way would be for a family to discuss their dreams or even be together in silence.

Although I have only referred to three basic skills in the development of capable young people there are many more we are aware of, the important issue is determining what skills we want our children to take into the future. According to the 1980 census figures, 33% of the Indian population was younger than 15 years compared to 23% of the U.S. All Races. Census Bureau figures also show that between 1978 and 1980, the birth rate of Indians was 30.2 (rate per 1,000 population), which is about twice the 1979 rate of 15.9 for U.S. All Races.[4] Statistically, we have the children. We need to ensure them of their future!

The following interviews are excellent examples of children who are developing as free, responsible, capable young Indians, qualities which were not provided at birth but are the results of parents, teachers, family and other members of the child's community.

[4]Reauthorization of the Indian Health Care Improvement Act, Part II: Select Senate Committee on Indian Affairs, United States Senate, March 17, 1984.

MY MOTHER IS A DOCTOR

This portion of the chapter is devoted to the children of our women medical students and physicians. It was to be made up of antedotes and stories of their lives, wirtten by children who have tolerated their mother's involvement in medicine.

The chapter was included to help dispel women students' and their mothers' fears of inadequate child rearing when a demanding career is combined with motherhood. It was to be the most delightful chapter in the book! Alas, travel funds and time have been prohibitive. Accept our offerings and realize that we have barely been representative of the wonderful children who have said with pride, "My mother is a doctor"!!!

"My mom had me during her pre-med training. I was delivered by an Indian woman doctor.
Kenneth Richard Lee Bernard, 6 months

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BRENDAN GOURNEAU
Age 11 years
Three Affiliated/Chippewa
Enrolled at Fort Berthold, North Dakota

Question: What grade in school are you?
Answer: Fifth grade.

Question: Are you glad your mom is going to be a doctor?
Answer: Yes, cause she could help people if they're sick. But I don't like it sometimes cause she has to go to school more–don't get to see her that much.

Question: Any of your friends have mothers who are going to be doctors?
Answer: No, but some of my friends' fathers are going to be doctors. Most of the kids say "your mom couldn't be a doctor," and "I bet" when I tell them she's gonna be a doctor.

Question: What's your favorite thing to do with your mom and dad?
Answer: On Saturday, eat breakfast at Hardees and then eat Chinese food for supper. In the summer I like to play outside all night.

Question: What is your favorite thing to do with your friends?
Answer: Break dance at Wilkerson Hall.

Question: Do you want to be a doctor when you are older?
Answer: No.

Question: What do you want to do?
Answer: Go to college on a football scholarship.

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GABRIEL
Age 10 years
Turtle Mountain Chippewa/Assiniboine

"My mother helps people by making them well if they are sick." "I like it but I wish she was home more. If she was home more, I'd ask her to take me places. My dad takes me places, but she would take me to a museum."

ANGELA
Age 5 years
Turtle Mountain Chippewa/Assiniboine

Question : Angie, what does your mother do?
Answer : She goes to the hospital.

Question : What does she do there?
Answer : Takes care of people.

Question : How does she take care of people?
Answer : When they're sick, she takes care of them, she give them medicine.

Question : And what else?
Answer : When they hurt really bad and they have bullets, she takes them out. She cuts them open and she tries to take them out.

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Question: Do any of the other kids have mothers that are doctors?
Answer: Some of them.

Question: How do they like it?
Answer: They like it good and they like it because they might be sick and they might have somthing wrong too.

Question: And their momma can take can of them?
Answer: Yes.

Question: How do you like your momma being a doctor?
Answer: I like it because, let me think, whenever I'm sick she gets the momiter (theremometer) and takes my temperature.

Question: What else does she do?
Answer: Whenever I throw-up, she wipes it.

Question: She does, huh?
Answer: Yah.

Question: Is there any problem with your momma being a doctor?
Answer: No.

Question: Would you rather have your momma be a doctor than anything else?
Answer: Yes.

Question: There isn't anything else you'd rather have your momma be?
Answer: Nah.

Question: What are you going to be when you grow up?
Answer: A teacher.

Question: Why are you going to be a teacher and not a doctor?
Answer: Cause then I can teach people how to be a doctor.

At this point in the interview, Angela's auntie couldn't think of more to ask. The child was obviously very satisfied with her mother's role.

Angela's mother describes her children as being very independent. Both have been placed in gifted children classes. The children mind well, and they can amuse themselves. They play well with other children. There is no hanging on a parent, or whining for attention. The effects of their parents' role reversal seems to have been borne well by the children.

In a more serious vein, one women, 24 years old, reflects on her mother's years in medical school while she herself was a wild teenager. She and her physician mother are very close now, yet both admit they had serious problems for awhile. The daughter is reluctant to blame the problems on the mother's medical career. She said, "I don't know. It could have been the constant moving. It could have been just my age. It could have been my relationship with my father."

"One year we were one of the most-respected teacher families living on our home reservation. We were well off. Then there was the divorce, and a move where my mom is teaching in a close-to-reservation college, but financially we had less to live on. Then she had another job and a better salary, with another move to a larger, off-reservation town, but still we were at an Indian communty. Then there was medical school with few Indian people and poverty level people in the community we lived in, as mom got a house she could afford in a good area. She made a wise buy, but we had less than any other kids in the area. I was just entering junior high. The values of the community were different. Mom was busy all the time. She gave me attention when I was bad, so I guess at times I got attention!"

Staying out late just before her mother's biochemistry exams was a favorite trick. The mother failed biochemistry. The mother had only had inorganic chemistry, a survey of organic, and one semester of regular organic (about six years before medical school) so the biochemistry failure was not the daughter's fault.

A younger daughter of the same physician talks about the time her dog got diarrhea and "messed" up the mother's biochemistry notes which were in semi-messy order on the floor of the study room. This daughter, a fifth grader about ten years old, had a spoon trying to clean up the "mess", when her mother walked in. There was another biochemistry test the next day. At this point, the medical student mother took the tearful child in her arms and they both cried. The mother than gathered up the soiled papers, threw them away, and took the child out to get a hamburger. This matter reflected to that child that she was more important than biochemistry. The mother realized that medical school was not that important, to make her daughter so unhappy. School seemed to go better for the mother after she came to that conclusion and keep her family as the top priority over her medical career.

STEELE FAMILY
Lois Steele, M.D., Stacy, Cary and Hunter
Photo used through the courtesy of the Minneapolis Star

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JUDITH SALMON KAUR, M.D.
Cherokee/Choctaw

The deep devotion of our Indian physicians toward their children was noted by husbands and families. The actions of Dr. Judith Salmon Kaur, Cherokee/Choctaw reflect this. Her daughter was born prior to medical school. Judith was a counselor, at the time, but took some time off from her career when her daughter was born. "One of the greatest experiences of my life was becoming a mother. I felt it was very important to stay home fulltime," she said.

As Krista approached school age, Judith also thought about school. She completed her pre-med requirements and entered medical school through INMED at the University of North Dakota. She finished at the University of Colorado and completed an Internal Medicine residency and hematology/oncology fellowship. She is currently on staff at the University of Colorado Health Sciences Center but also is acting as a consultant for Indian people with cancer in places like Standing Rock Reservation. She has publications and research grants in oncology. Krista has certainly not handicapped her mother's career. This should be an inspiration to the mothers out there who are worried about the demands of a medical career.

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However, not all medical fields are alike. Vicky Stevens answered, when we asked if she had a family..."No, are you kidding–a female surgeon?! This is one area my Indian family thinks I'm really weird about-fortunately I have 11 brothers and sisters with a total of 40+ children, so the pressure's not too bad."

There was a section at the American Medical College meeting, 1984, by Maureen Sayers, who discussed pregnancy and women in residency. The conclusion was that the biggest problems the women face is the resentment of the house staff. The administration and directors of residency programs again mentioned that it is very hard to handle unexpected pregnancies, and they do resent women becoming pregnant during the residency program. It is important that women realize that there is a Pregnancy Discrimination Act of 1978; and some state have laws supporting up to 13 weeks leave for pregnancy.

The usual 100 hours per week that residents work is to high for a pregnant women. Even 75 hours per week may be too much. Information on flexible scheduling for special conditions, and ways to avoid radiology and anesthesiology during pregnancy, should be available to women residents. Women will need help by networking, to enable friends and other parents in the region to help one another. Indian women do not seem to have as many problems with the baby-sitter if they attend school close to the reservation.

Women in medicine express very real guilt feelings at leaving residency to spend time at pregnancy or child care. Many feel that this guilt was fostered on them by other residents or the directors of the residency programs. Guilt is a very destructive emotion, and it does not help women through post-parum depression, which in a normal physical condition; nor does it help her cope with the increased load she has during the pregnancy and after the baby is born. We are starting to see a minimal number of men who have changed their career paths for a wife who is an M.D. I see this happening at INMED, and the women seem to have had an easier time emotionally than have women who have gone through it alone.

There are solutions, such as increasing awareness of the probelms; and speaking to the positive aspects of families and medicine, rather than the negative aspects. Women in medicine have an obligation, to support positive pregnancy rules and to allow time and support for other women physicians' family activities. This will help to prevent impaired physicians, both male and female.

We need to provide resources for couples to talk to couselors within the residency programs that are outside the administrative hierarchy. The counselors should be available so that people can talk to them without taking time from their schedules, and without fear of the counselors being able to use this information to get rid of a resident who is having difficulty.

State and federal laws concerning pregnancy of employees should be followed by residency programs. Hospitals are now having a problem as to who are employees and who are students. The hospital's narrow view is usually due to economic reasons,

and consequently they want students to be considered students and not employees . Students have less rights than employees. The taxation question on a student stipend induces residents to fight to remain students rather than employees. Since the males outnumber the females in residencies, it again discriminates against the rights of women who want to have children during residency.

Ronald G. Lewis, Cherokee and Professor of Social Work at Arizona State University, has written some editorials on the strengths of the American Indian family. Since the center of the American Indian family is the women, it is necessary that we look at these roles as we define the roles of the Medicine Women in our culture.

Lewis notes that social service personnel often describe Indian families as pessimistic and stoical. As one looks deeper, another perspective Lewis declares, "in the midst of abject poverty and sorrow comes 'the courage to be,' to face life as it is and yet maintain a spiritual optimism." It is this spiritual optimism that we wish to carry through this whole book on medicine women. Women who have declared they will take care of not only their families, but also of other people who are sick and in need, women who have trained themselves academically, these women must have a spiritual optimism for the strength they will need. This may not be defined in terms of any particular doctrine or sect or denomination, but as Lewis notes, it is defined as a spirit of seeking peace with nature, with your fellow beings, and with the Creator. It is difficult to maintain a spirit of cooperation rather than competition when you have one foot in the medical society and the other foot in the Indian world. The Indian world speaks of cooperation, of being in tune and in rhythm with the earth. The medical society of the non-Indian world is trying to regain some of this feeling through current discussions of holistic medicine.

The spiritual optimism is one strength

...The second strength is the spirit of cooperation between the families as a grandmother may take in young people although she's receiving no financial aid for her efforts and may even be on welfare herself.

...The third strength is the deep interpersonal relationships with the respect, the key of all relationships regardless of age.

As I, Lois Steele, M.D., mentioned in other places and ways in this book, I feel we have to accomodate to the society if we are to survive or if we are to gain the education to practice non-Indian medicine as doctors, nurses, and other health professionals. This must be done realizing the sacrifice and yet preserving the rich legacy of Indian values our grandparents taught us.

The duality of the system that American families have to cope with described by Helen Jackson as a "Austere Puritanical" ideology in a competitive consumer society is made even more complex when you have to also live in the

Indian world where you should be helping other Indian people and giving to those that have less than you. This is touted by Christian doctrine, but not supported by the rest of the messages that honor conspicuous consumption by Americans.

INMED GRADUATES
Ida Campagna, M.D., with Mike Claymore D.D.S.

Ida went through medical school as a single parent. She is now practicing Obstretrics and Gynecology (OB-GYN) in a solo practice. Many young women with children call INMED and ask if it is possible for them to go to school with children. Ida and Mike in this book are living proof that much is possible, with hard work and help from family and friends.

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HAVE A NICE DAY
SmiLe
HOW BIG ARE YOU ?
4F
3F
2F
1F
KINGS

HOUSEHOLD HINTS FOR RESERVATION BACHELOR"ETTES"

Since we all know the Lakota Times is a fair and just publication, I felt it my journalistic duty to represent the other side of the "bachelor life" as it now exists on the reservation according to Adrian Louis. So, for all you girls out there of the terminally single persuasion, here is a handy guide to make your existance a more successful, fulfilling and non-nauseating single life.

(1) When driving a nail into a hard piece of wood, look disgustingly pitiful and fragile (a slight hint of tearing in both eyes should also do the trick) and call Plant Management. We all know most Indian males will never have a decent, working knowledge of brute, macho things such as hammers, screwdrivers, venetian blinds, and washcloths.

(2) If you just cannot "handle" such domestic tasks as ironing--just tell everyone you wear clothing like that because Vogue said, "wrinkled" is "in".

(3) Bag those romantic homecooked meals. A candle can prove to be hazardous if your beloved snag decides to lean over the table to give you a little smooch and his braids or ribbon shirt go up in flames.

(4) Never tell your man to come "right" over. Be sure to hide the cheez doodles, dexatrim, BRIDE'S magazines and those ugly little house apes we all refer to as, "little brothers."

(5) When faced with a lawn you can no longer ignore, or your neighbors can no longer ignore, simply grab a string bikini or any such revealing outfit and help should appear instantaneously (as well as very anxiously) ready to do a snitz job.

(6) When plagued with disgusting animal hair about the house, either shave your pet or buy a vacuum cleaner. Both are sufficient answers to this perplexing problem but can really depend on your present financial situation. You'll either have a very chilled-out cat or a cancelled trip to the next Pow-Wow. Make your choice...

(7) Be sparing with your jewelry. Don't weight yourself down when he takes you for a romantic romp in the "krick."

(8) Yes girls, let's all keep in decent shape but DON'T overdo it. The male ego is easily bruised and it's an ugly sight to see our Indian male population out there chowing down on commodity quiche.

(9) When bothered with those creepy-crawly things like flies, spiders and yard snakes, just pull any drunk in off the streets and ask him to breathe on those nasty pests. Fumes radiating out of his mouth will either kill it instantaneously or put it in a drunken stupor. You're covered either way.

(10) And finally, when those troublesome relatives come to stay over during the pow-wow and never seem to leave-simply tell them "it's funny how easily one can contact herpes, isn't it?" and you should have no trouble from them any longer.

(11) Beware of Northern Paiutes bearing gifts.

I hope this has helped any of you out there like me-hopelessly single. We need all the help we can get. But, as you very well know, advice doesn't come cheap. So, don't be surprised if you hear a strange tap on your door late, late some night. It'll be me, that is, if there's a pow-wow nearby...

(About the author; Tracy Lebeau is an enrolled member of the Cheyenne River Sioux Tribe.She will be a senior at Alamada High School this Fall and wants to pursue a career in journalism.)

Published in LAKOTA TIMES

This is included in this intense chapter to give humorous hints on how to cope. All Medicine Women face some of these problems, whether you are single as most of us ,or married as the minority. Those Grandmothers among us would not do well with Number 5. Of course, we might look so ridiculous that the local "help" might "appear instantaneously" to get us out of sight.

We wish to give credit to Tracy Lebeau and the Lakota Times for the "Hints." However, we do not have the exact volume and page so can only do it Indian way and say "pielama."

CHAPTER IX

MY MOTHER WAS ONE OF THE FIRST INDIAN NURSES
by Connie Jackson

Author's note: This chapter was sent to INMED by Constance Joy Yellowtail Jackson, "Blue Bird." Connie has been one of the hardest working INMED Advisory Board members for nearly eleven years. She represents the Crow Tribe on the Board. Her dedication in part stems from the fact that her mother was one of the first Indian nurses, if not the first. The dedication of Susie Yellowtail is well known. The deep loyalty and equal dedication of her daughter Connie, to further the educational opportunities for other young Indian people, should also be recognized.

The material Connie submitted reflects a unique blend of religious beliefs. It is not the purpose of this book to preach any doctrine. However, Connie's message is so profound, it would not do to edit or alter it. She has endured much sorrow and still she thinks mainly of others; and of trying to give women the strength to become good Medicine Women.

At an Advisory Board Meeting last year, one of the INMED students was complaining that not all the other students were "traditional" Indians. After listening to the complaints for over half an hour, Connie replied in this vein, "We are educating you to take care of all people, Indian, Black, White and others. We don't want you to judge, just stop their hurting. If you can't do that you shouldn't be in medicine." Connie realized that in a healer, bigotry can be destructive. This situation is typical of the wisdom she brings to the Board meetings. Her thoughts below are compiled from living and listening to others, a practice we might all cultivate. She has many quotes and ideas from the Bible, this also is a way to gain strength to face difficulties.

As the Apostle Paul told us, be just, kind, mild and loving; speak always with honor and truth; stand like a shining pillar in the darkness; be honorable and temperate of the speech and manner; be joyful that others may know your joy; avoid open or private sin; pray always. So you will draw others to you, in wonder, to be enlightened, and to be saved. This is an evil world, He who can point the way to peace, justice, salvation,everlasting joy and love is a messenger of good tidings. For He comes asking not for money, position or favor for himself. He asks only happiness for the souls of others. This alone is a stupendous request, before which all men must stand in amazement and awe.

A man's pride in his past and in his nation is a powerful thing, and woe to that man who belittles it. Warn your people to be temperated in their zeal, and not to

offend, and not to insult the gods of others. In short, let them practice what they preach and exercise a measure of tolerance.

I HAVE RUN THE RACE, I HAVE FOUGHT A GOOD FIGHT
CHIEF JOSEPH

BLACK ELK'S VISION

He was nine years old and taken sick. During this period he had a vision: horses escorted him to his grandfathers in a cloud that turned into a teepee, and a rainbow with its the open door, and through the door were six old men. The ancient ones had called him here to teach him, they were the powers of the world. First was the power of the West; the second, of the North; the third, of the East; the fourth, of the South; the fifth, of the Sky; and the sixth, of the Earth.

> "First Grandfather spoke again, Behold them younder where the sun goes down, the thunder beings! You shall see, and have them from my power? and they shall take you to the high and lonely center of the earth that you may see? Even to the place where the sun continually shines, they shall take you there to understand'...
>
> "Now there was a wooden cup in his hand and it was full of water and in the water was the sky. 'Take this...it is the power to make life, and it is yours.'
>
> "Now he had a bow in his hands. 'Take this...it is the power to destroy and it is yours'... Then he pointed to himself and said: 'Look close at him who is your spirit now, for you are his body and his name is Eagle Wings Stretches.' (Then he turned into a shinny black horse)...
>
> "Second Grandfather...arose with a herb of power... 'Take courage young brother...on earth a nation you shall make live, for yours shall be the power of the white giant's wing, the cleansing wing' (a goose)...
>
> "Third Grandfather...'From them who have awakened all the beings of the earth with roots and legs and wings' (he offered a peace pipe)...'With this pipe...you shall walk upon the earth, whatever sickens there you shall make well.'
>
> "Fourth Grandfather spoke...'With the powers of the four quarters you shall walk (a red road)...'Behold, the living center of a nation I shall give you, and with it many you shall save...'and I saw that he was holding in his hand a bright red stick that was alive, and as I looked it sprouted at the top and sent forth branches, and on the branches many leaves came out and murmured, and in the leaves the birds began to sing...'It shall stand in the center of the nation's circle, said Grandfather, 'a cane to walk with and a people's heart, and by your powers you shall make it blossom...'In four ascends you shall walk the earth with power.'

"Fifth Grandfather spoke, the oldest of them all, the Spirit of the Sky...'Behold, all the wings of the air shall come to you, and they are the winds and the stars shall be like relatives. You shall go across the earth with my power.' Then the eagle soared above my head and fluttered there; and suddenly the sky was full of friendly wings all coming toward me.'

"Sixth Grandfather...Spirit of the Earth. (He was old and grew backwards, becoming young again. He was Black Elk himself and grew old again) He said...'Have courage, for my power shall be yours, and you shall need it, for your nation on the earth will have great troubles -- come.' He rose and tottered out through the rainbow door and as I followed, I was riding on the bay horse who had talked to me at first and led me to that place. (A voice spoke to him and reminded him of all the gifts that his grandfathers had given him and led him to the land where three rivers came together. He saw a war against his people and heard the cry) 'Eagle Wing Stretches, hurry!' (Black Elk was shown how to overcome the enemy with each power of the grandfathers, and how to overcome each obstacle.)

"(When it was over), the daybreak star was rising and a Voice said, "It shall be relative to them, and who shall see it, shall see much more, for thence comes wisdom, and those who do not see it shall see dark, and all the people raised their faces to the east, and the stars' light fell upon them, and all the dogs barked loudly and the horses whinned. The great Voice said, 'Behold the circle of the nations hoop, for it is holy, being endless, and thus all powers shall be one power in the people without end. Now they shall break camp and go forth upon the red road, and your grandfathers shall walk with them."

Everyone left the camp. The horses first, carrying all the sacred medicines and powers; the people, youngest first, old women bringing up the end and last, Black Elk, riding the bay horse with the bow and arrows that the First Grandfather gave him, and when he looked behind him, he saw the ghosts of Grandmothers and Grandfathers. And one of these great voices behind him said, "Behold a good nation walking in a sacred manner in a good land!"[17]

I am presenting to you the views of Paul, Christianity in its earliest existence, through these of Black Elk, to point out to you the existance of the Supreme Power.

The reason behind this is to bring forward the question everyone has on their mind, "why am I here?."

17 John G. Neihardt, Black Elk Speaks (New York: Washington Square Press, 1932), excerpts from pp 22-30.

We all come to a time in our lives when we question why am I here, and what difference does it make? Does my opinion count, and if I have an opinion who cares anyway? Some poeple go on with their life styles, doing what is expected of them, even though they may be unhappy with it; perhaps to satisfy their parents, or to try and surpass a fellow human being; if they are a competive type. There are those who push themselves to the limit and burn out and wonder why? There are those who say, "let someone else do it, I'll just hang around and see what happens, maybe so, maybe no." Eventually a little voice inside of ones' self starts asking questions, "why this and what that?" Some people say "it's your conscience." "My conscience, (however), bothers me." That folks, is God talking to you! He is wanting to help you and when this happens, one had best listen. There's no use wasting time, believe me. Listen and heed it, by listening to that inner voice, you will save yourself and your loved ones much grief. You have a place to fill in the world, one no one else can fill. You are important in God's plan whether you want to believe it or not. Your reputation is made by searching for things that can't be done and by doing them.

Instead of putting others in their place, try putting yourself in their place. Can you congratulate a friend who has accomplished a great deal? Can you share one's grief? Can you forgive one whom you think has done you a wrong? Can you thank those who have sacrificed for you? Can you thank those who have scolded you? Can you ask for forgiveness and most importantly, can you tell your friends how much you love them?

The Almighty One has given each and everyone of us gifts. Stop! Look! Listen! Pray about it. Slow down, take time out to think about it. Call upon your ancestors,. your God! Don't despair, don't wait! Don't blame your parents, your primary teachers, your bus drivers, BIA, tribal leaders, etc. Look above, call to those who have been here before, and the mightiest of all spirits, the Holy Spirit, who comes to all human beings in what ever form He has chosen to invade their souls, whether it be in Nicaraugua, Nepal, Shanghi, England, Israel, Russia, New Zealand, U.S. or wherever.

We're all humans, created from God's desire. So don't despair. Use your gifts! There is so much joy in living, in learning in the primary grades, learning about the world, and all its' people, learning how they live in other countries. There is joy, in music, prose and poetry, dance, drama, medicine, politics, history, medicine, art. Put fear behind you. Laugh at your fears! Who was it that said, "there are no problems, only solutions"?

Women are the backbone of the country. This is the best hidden secret of our time. Everyone tries to put women down, but did Jesus? Did God? Think! And look at history! Who is Mary? Who was, clear down to Sister Teresa? Consider your grandmother, what influence did she have on your life? You own mother. It is a fact your mothers are always there to help you! Call on them. God will let them come to you, either in a vision or a dream. They never blame us. We have a lot of work to do and we never give up. We know our work is cut out for us: to alleviate the suffering of human beings, to bring tenderness, comfort and joy to humanity, and the wisdom to know when enough is enough. As in times of great distress, I have called upon my mother's Sioux Ancestry, which is my priviledge. They have always responded; also have my Tetonion relatives with great respect.

I also have had visions, seeing a parade of our people, and at the end of the entourage went an old woman with a child on her back, wrapped in an army blanket. When they came within eye sight, it was my own dear mother bringing up the rear. I said from my place with my daddy on the hill, "Momma, is it really you?" and she nodded and said, "yes my girl." I cried aloud and said "Momma, now I know what a burden you carried, let me carry the baby for you." My precious mother bringing up the rear of the people with a child on her back! She who dreamed of "Teepees For Children," she who was called away on Christmas day three years ago this 25th of December. The holiest of all days! There are no doubts in my mind where my momma is. She's surrounded by angels! Lord willing, my family will accomplish her dream of "Teepees For Children," and hopefully they can be nurses, as she was, maybe even becoming doctors, without having to be away from one's family for 10 years; with no news from home in all those years. Not even a government grant and people trying to convince you that you are a heathen and no one to back you up. Clear in Massachusetts where the Pilgrims landed. Did my mom go under? No, she sure didn't! She worked in Boston, clear back in 1925, and later in Chicago, and finally returned to the Crow Reservtion as a R.N. You've heard about the CHIP's? That's her baby! She worked hard, after she raised us, ask Annie Wanaka or Pat Locke, they'll tell you; or Dr. Johnson; yes, determination does it.

My littlest girl went to the same prep school as my mom, Northfield Mount Herman, Massachusetts. At her graduation, they honored my mom, Susie Yellowtail, along with my daughter, Lesley Jackson, as being great ambassadors for all Indians and especially for the Crow Tribe! Lesley looked back to see where we were heading (graduation exercises were held on the football field) and her Gramma was there, between her Grandpa and I, waving to her! Praise the Lord, she's here when we need her. Lesley, my youngest, went on to Stanford and is in her second year there, along with Tim Wilson and Debbie Phillips, both from Montana. Tim is a Northern Cheyenne and a graduate from INMED.

So, who's to argue? He wrote "Go for it, be yourself, be who you are, this is your chance to have a new experience and learn from others."

Thank you and God Bless,
Constance Joy Yellowtail Jackson.
"Blue Bird" INMED Board,
Vice-Chairperson, 10 years.

CHAPTER X

INDIAN NURSES

There are presently about 1500 Indian nurses, about three-tenths of 1% of total nurses in the nation. However, in 1983 approximately 1000 Indian nurses were employed in the Indian Health Service compared to about 2600 non-Indian's employed in the Indian Health Service.

RN's*	INDIAN	NON-INDIAN	TOTAL
Government Pay Grade:			
GS-4	14	7	21
GS-12	29	34	63
GS-13	4	5	9
Director of Nursing	27	21	48
RN's in area IHS Offices	481	1397	1878
Intermittent & Part-Time RN's			
Full Time			
Permanent	474	1157	16,381

The role of nurses in Indian health care and the conditions under which they work has been described by Doris Giago in The Lakota Times article on the following page.

*Taken from AIANNA Newsletter, 11/83, Vol. I, No. 1.

Shortage of Nurses Critical
at Pine Ridge
By
Doris Giago
Times Associate Editor

PINE RIDGE - A shortage of nurses has reached epidemic proportions at the Pine Ridge Hospital and there's no relief in sight, according to the doctors, nurses and hospital administrators.

"There has been for a long time and there continues to be a shortage of nurses at the Pine Ridge Hospital," said Dr. Roy Marnard, pediatrician at the hospital since October 1.

Other doctors share his concern. "There just are not enough nurses," said Dr. Pam Bucklew, general medical officer, who has been at the hospital for the last 15 months. "To be able to handle the patient flow, we need more nurses," she said.

"I definitely agree with the doctors," said Terry Pourier, service unit director, Pourier said he has been aware of the problem for some time and has been working on ways to solve it.

In July the Joint Commission of Hospital Accrediation evaluated the hospital. "During the July 17 accrediation survey of the Pine Ridge Hospital, the nursing surveyor (evaluator) cited that the nursing staff required additional positions,"said Dr. Donald Smith, clinical director for the hospital. "They felt the quality of nursing was very good, but we just did not have enough nurses to handle our current patient load," Smith said.

Pine Ridge has 23 beds in the medical-surgical ward, 10 beds in the obstetic ward, and 11 beds in the pediatric ward, with a total of 23 registered nurses at the 54-bed hospital.

"But seven of the nurses do not do patient care," said Dorothy Lafferty, acting director of nursing. "So really, there are 17 nurses that take care of the patients in the hospital," she said. Those 17 nurses cover 21 shifts a week. Besides the RN's, there is one or two LPN's, and an aide are on the floor at various times.

Until, and if, Pine Ridge Hospital acquires more nurses, the present nursing staff is forced to work harder and longer hours, according to Jeanne Pourier, who up until a few days ago was the director of nursing and is now director of community health nursing.

"The nurses average 20 hours of overtime a week," Mrs. Pourier said. "Pine Ridge is a demanding place to work because of the shortage of nurses and the heavy patient load. The nurses are running constantly," she said. She said the nurses are so busy that many times they work through their lunch break.

"Nurses are in charge of everything," she said. "I don't think people realize the hours and the work the nurses put in,"

"We have to be the nurse, the ward clerk, the telephone operator and the buffer between the patient and the family,"said Gwen Ward, staff nurse at the hospital.

Ms. Ward has been called in on her days off to help out at the hospital and on several occasions has accompanied patients who have been transported to other hospitals for care they couldn't receive at the hospital because of shortage of nurses.

"I was called in on my day off to take a patient to Denver. I got back at 3 a.m. and had to get up to go to work at 8 a.m.,"she said.

"I've stayed a good deal of time after my shift was over just to do chart work because I was too busy during my shift to get it done," she said.

"The patients suffer because of the shortage," said Mrs. Lafferty. "It means longer waiting time for them. You don't do as good a job as you could," she said.

"Nobody dies as a result of it because we send the patients out that we can't care for to either Gordon or Rapid City Regional. If we had the nurses here to take care of the patients, we wouldn't have to send them to other hospitals," she said.

"This is inconvenient for everyone," said Dr. Bucklew. "A patient doesn't feel comfortable in another hospital. It creates a hardship on the family also."

"I hate to see patients shipped out, especially the elderly patients," said Ms. Ward. "I definitely think it plays a part in their deaths.

"When you send the elderly away from their family to a different area, there's a cultural differences and there's a fear any patient has when they get sick and have to go to the hospital," Ms. Ward said. "And all these compound the initial problem," she said.

Dr. Maynard said since he has been at the Pine Ridge hospital he has sent six patients to the University of Minnesota in Minneapolis. Some of the patients could have stayed at the hospital in Pine Ridge if there were enough nurses to monitor them.

With the cold weather coming on, Maynard said he is concerned that there could be a real problem if the hospital can't handle the case load.

"I've seen more respiratory diseases here in six weeks than I've seen in Minneapolis in six months," he said.

The cost of sending patients to other hospitals is enormous, the doctors said.

"If a team comes in from Minneapolis to transport a patient, it cost $3,000 to $4,000," said Darlyne Clements, contract care clerk. "If we charter a plane and send our own nurse, the cost is $800. "These amounts do not include the stay in the hospitals, she said. Mrs. Clements said the budget is $2.4 million a year.

"The shortage of nurses is a complex problem," Ms. Ward said. "It isn't any one person's fault. It's the system's fault. Then you compound it with a geographic factor. Who wants to come to Pine Ridge?" she asked.

And the personnel office in Aberdeen agrees. "Nursing is a shortage category and it's difficult to attract nurses to those remote locations," said Lee Miller, program management officer for human and manpower resources at the Area Office.

"It's not that efforts aren't being made to find nurses," Miller said. "It's just that we aren't getting the applicants. We have made efforts continously but the applicants have to show an interest in Pine Ridge."

"It's unfortunate the way the government works," said Pourier. "It's costly. Many times you have the dollars to pay for nurses but it's the position ceiling (quota of nurses) that holds us back from getting the people," he said.

"I realize we need more nurses. I've done all I can," he said. "Immediately, I don't see anything coming down for awhile, unfortunately.

Pine Ridge is a large, sparsely populated reservation in South Dakota. Many people still speak the native language. The funding problems of health care in the upper Plains is mentioned in the article. The enormous problems of the whole area were tackled by another Indian nurse from Sisseton, South Dakota, Eleanore Robertson. She spent about five years as Aberdeen Area Director and managed a 70 million dollar budget. In this short span of time she gained tribal support and input and filled physician positions that had long been vacant. She recognized talent in other women and encouraged them to gain more training and then elevated them to positions worthy of their talents. She is truly a mentor to many other women.

One nurse that was allowed to demonstrate her vast talent in administration under Mrs. Robertson, was Lorretta Bad Heart Bull. Lorretta tackled one of the service units that had had a lot of personnel turnover and constant problems with physicians. She firmly took command and brought stability and a full cadre of physicians who could work together to the service unit. She was able to return to school to secure more training to enable her to advance. Lorretta had overcome many setbacks prior to this. She had been in a serious auto accident in which she lost a leg. She never let this really slow her down, but set an example with hard work.

The Wonder Woman among American Indian nurses is Phyllis Old Dog Cross. Phyllis, an enrolled member of the Mandan-Hidatsa tribes, won the Wonder Woman Foundation award for 1982. She has a master's degree in nursing, awarded in 1962. She has had varied professional experiences such as: five years in the U.S. Air Force Nurse Corps, including three years as a flight nurse assigned in the aero-medical evacuation of patients in Europe, North Africa and England to the United States. She is a veteran of the Korean War. She has had leadership positions in places like Colorado Psychiatric Hospital, Boulder City-County Health Department and University of Colorado Emergency Psychiatric Service.

Phyllis entered federal employment in 1970 as a Mental Health Nurse Consultant with HSMHA Region VIII. She was then appointed special assistant to the Regional Director of HEW Region VIII where her duties included Federal Regional Council liaison and coordination of Indian affairs in Region VIII. Five years later she was responsible for coordinating activities at the national level for the Bureau of Indian Affairs in improving services to Indians.

Phyllis has a wide background in serving on advisory committees, doing workshops on minority rights, women's rights and mental health. She has contributed to several publications including:

- Out of Uniform and Into Trouble: A study of the role of the nurse in the comprehensive community mental health center; a book review of Bury My Heart At Wounded Knee for the Montana Historical Society and a chapter in this book Medicine Women.

She won the Wonder Woman Award as a "Woman Helping Women." Her numerous presentations and work on stress, family violence, rape, affirmative action and

other mental health topics show that she has really earned that title.

Phyllis, the hard working nurse, is soft spoken and gentle in her movements. She sits quietly throughout meetings until she needs to raise a question or give an answer to a complex problem. Her strength comes through the many experiences and even the hurts have molded a very unique woman.

Ladies Home Journal chose her the outstanding woman from South Dakota in 1984. The students that have benefited from her efforts to provide scholarships will probably always think her as "outstanding," and a real nurse to model their lives after.

There are other outstanding Indian nurses we were unable to contact. We could not cover more thoroughly due to numerous reasons. However, we did hear from many interenting women. The rest of this chapter is about them.

Lorene Sanders Farris, RN, Ed.D., has many publications and an outstanding vita. Lorene, a Cherokee, states that there are now less than thirty Indian RN's with Master's degrees in Nursing. She is truly a role model, possessing her B.S. and M.S. in nursing after starting her career as a diploma nurse. She also remembers, as does Rosemond Foines, receiving much encouragement from staff at Indian boarding schools, in this case Dwight Mission Presbyterian Indian school and Sequayah Indian school, Tahlequah, Oklahoma. Her dedication to furthering opportunities for Indian people expresses itself in numerous publications. She feels that women can prepare themselves for education and a health career...

> "While in elementary and high school, study, set goals, and try to decide what it is you want to keep that in mind, all of the time. There is a real need for Indians to be in the profession so they can help and encourage others to seek help for illness and to seek ways to remain well. Also be aware of all of the financial opportunities that are available for study and even if it is not for Indians or other minorities, apply for the grant or at least write for information and know what is available. Try to find a role model or mentor in the Indian community so they can provide emotional support when there is lots of stress.

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PUBLICATIONS: Farris, Lorene, RN, Ed.D.

"This I believe about Nursing", written for and included in the publication Contemporary Minority Leaders in Nursing, American Nurses Association, 1983.

Farris, Charles and Farris, Lorene, "The American Indian" Culture and Childrearing, Ann Clark, Ed. Philadelphia: The F.A. Davis Co., 1981.

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Farris, Lorene. Apporaches to Caring for the American Indian Maternity Patient. The American Journal of Maternal Child 1976, 1 (1).

McClain, M.E., and Gragg, S., Scientific Principles in Nursing. 3rd Ed. St. Louis: C.V. Mosby Co., 1969. (Contributed two chapters: Personal and Community Health and Nursing Care of the Long Term Patient).

Dissertation: Farris, Lorene Sanders, "A Study of Factors Associated With Success of American Indians in Nursing and A Proposed Model for Cultural Content," University of Miami, Coral Gables, Florida, June, 1983.

Time constraints did not permit us to include ideas from her printed work, but she probably has written more prolifically than any other Indian woman in this area.

She is a nurse who was an orphan and received her encouragement from a school nurse at an Indian boarding school. The nurse and school superintendent helped her to make arrangement for a B.I.A. loan and help from the Daughters of the American Revolution.

Dr. Farris attended a diploma school of nursing. She eventually obtained a B.S. and M.S. in nursing and a Ed. D. in leadership. She exemplifies the creativity and hard work necessary to achieve publications in scientific journals.

Indian women have faced hardships in pursuing careers in nursing and also medical careers. A few women have allowed us to share theirs with you.

The OHOYO newsletter stated, "Nearly one-fourth of all American Indian households are headed *by* women with no husband present. This is more than twice the nagional average." This data came from the 1980 Census Bureau Study. Of a total of 455,503 American Indian youth under the age of 18, OHOYO analysis revealed that one out of every four Indian youth resided in a single-female-parent household. ....The median age for the American Indian was 23.0 years compared to 31.3 for the U.S. population....The national annual median income for a traditional family headed by a married couple is $23, 141, while for a female head of household with no spouse present it is $9,320. Data has not been released to reveal the median annual income for American Indain women who head households but it can be expected to be dismal indeed."

The above statistics are substantiated by the hardship the nurses describe when asked: "Please explain any financial or other hardships you encountered during your education, if any?"

LORENE FARRIS, RN, ED.D
CHEROKEE

Finances were the major reason that I attended a diploma school of nursing rather than a degree program, in doing so, it put me behind others and later I had to take many more courses to obtain a bachelors degree in nursing. In fact, I went without a lot of clothes, tooth care (dental), entertainment, and so on, due to finances. The fact that I was an orphan made it unusually hard because I had no family to ask for help. I always felt different because others had family to call upon. Later when I was able to obtain advanced degrees, I became very eagle eyed in looking for grants, fellowships and scholarships.

GRACE ELIZABETH LOUISE LINCOLN
ESKIMO

Earning a living and going to school was very hard on me. I worked as a nurse at night and attended school during days. I was often sleepy and

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lost weight and could not continue without injuring my health further. I am also sun sensitive, having been diagnosed as having lupus erythematosis at that time.

MAXINE CHUCULATE
CHEROKEE

My mother provided necessary support until her illness and death. Fortunately, I was provided with a working scholarship at Haskell, a tuition grant at Kansas University and then a loan from B.I.A., which covered minimum expenses as a student nurse at Kansas University Nursing School.

JEWEL C. SLICK
OGLALA SIOUX

No financial support for tuition, books, etc. because of Indian Education loan. Never had money for basic needs or spending money, my family was poor, $5.00 per month was allotted to me.

RUTH W. BACKUP
ATHABASCAN

If I had not received a scholarship in school, I would never have gone to nursing school.

JOSEPHINE T. WACONDA
ISLETA PUEBLO

Having lived on an Indian reservation all my life I felt very secure there and actually did not want to go out-of-state to school, although I had been offered an academic scholarship to Case Western Reserve University and Simmons College, Boston to pursue a nursing degree. I actually turned these down to remain near home.

EDITH RAMSDELL
ARAPAHO

I had five children at home when I entered nurses training--time was so limited for them with my homework, I had a marriage that was failing, teenagers (2), limited finances.

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MARY SUE MOSELY
CHEROKEE

states : her sister, a nurse, who is ten years older was her role model. Her sister and brother-in-law were her support systems. They paid for most of her education although Mary Sue was employed as a nurse's aid during summer months while in high school. She realized that there were financial hardships on her sister and brother-in-law, but they never discussed these burdens with her. She contacted tuberculosis while at Vanderbilt University and had to leave school for a few months. When she transferred to Missouri University, Vocational Rehabilitation paid the expenses. She later received a grant to complete her Master's degree. She now is working as a psychiatric nurse counselor responsible for the alcohol program in Oakland Park, V.A. outpatient clinic.

Nursing : The Changing Profession

The formal educaiton of nurses began in the early 1800's as doctors were increasingly being trained in hospitals. Patients needed to be cared for and hospitals kept clean.. Women from religious orders and lay women moved to care for the ill and dying. The profession of nursing became indispensible in the operation of hospitals.[18]

The American Indian/Alaska Native Nurses's Association has determined that Susie Yellowtail was the first American nurse. She was a product of the missionaries, having been orphaned at a very early age. She was a graduate of Northfield-Mt. Herman Massachusettes. She'd seen many years and died in the early 1980's on her own Crow Reservation, where many of her family still lives. Her daughter Connie Jackson has worked hard to help other people become health care professionals, such as her mother was.

Nursing is the medical profession that is in the shorest supply in the Indian hospitals. There are more Indian nurses than Indian physicians but the need for nurses is greater. The hardships of reservation life deter nonIndian nurses more than non-Indian physicians at present. Nurses are in demand across the nation, so will often stay where they have more back-up, more flexible schedules and less responsibility. The changing emphasis on who receives scholarships should help replenish the nursing ranks of Indian Health Service. The new regulations in hospitals with Diagnostic

[18]Health Careers Network, August 1982, Vol. 1, No. 4.

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Related Groups (DRG) is also changing the numbers of health professionals in various parts of the national health system. Hospitals are cutting positions to cut cost where ever possible. This will bring another set of problems for nurses. The problems with over work and burn out will continue to plague hospitals until they are able to treat nurses better, in the area of wages, benefits and hours. The economics of hospital management may make this situation more unsolvable as support staff is cut in an effort to save dollars. Will this make more nurses available to underserved areas such as reservations? Probably not, since the nurse's family will have problems securing employment on reservations.

American Indian nurses were contacted by Nancy Lindgren to get a profile of attitudes and motivations. Some of the interesting remarks include the following:

> It is important for the individual to determine his direction, function and goals for the future. Once a decision is made, the best way to reach the goal is through education. There are many obstacles that tend to deter one from reaching their goal. No one ever said it was easy! But without the determination to succeed, little will be accomplished if she doesn't strive forward and find the fulfillment each person needs within one's self.

> If it is a health career one is seeking, become involved in health care activities, committees and organizations, learn all you can about cultural differences of individuals. Be motivated enough to make one's self aware of educational resources and follow through by applying for these resources to help finance your education.

> Discover the talents you have and develop them to the fullest extent, through experience, education and determination.

She received encouragement to become a nurse from the staff at Haskell. She noted that whatever career you chose, all efforts were made at this Indian Institute to help you accomplish your goal. Her tribe helped her financially. Her help from her tribe and other Indian people may explain the dedication she has shown in Indian health education and as "advocate" for providing needed health services to Native Americans. She states from long experience: "I believe preparation for a health career is important, when I was young we had a support system that was so strong it enabled us to succeed in our chosen career – to recruit is not enough – the follow up to recruitment takes place to the completion of the educational process is important in order to show the impact of that effort. Dedication to one's people–knowledge of the responsibility of being Indian and action to put that knowledge to work. And most of all, caring, sharing and respect."

Josephine T. Waconda, Isleta Pueblo, has lived on her reservation all her life. She stated that Pueblo traditional ways are very important to her and have remained a part of her life. She encourages students to:

Trudie Narum, Jemez Pueblo lived in a 8X20 camper trailer in the desert for four years while attending college. She had to drive fifty miles one way to school. Her family consisted of two children and a husband, who was also in school. They survived without running water or electricity during those years. The fact that they were raised in a like manner, having their own garden, knowing which desert plants were edible and without running water or electricity helped them survive. She spoke to other women these words of encouragement:

> "Perseverance, don't allow yourself to fail. One may fail courses via grades, but don't look at grades as a self failure, recognize it was a difficult course or you didn't understand and try it again - - never give up. After all we are in a sense, learning a foreign language because we are attempting the Anglo's ways in education, medicine and lifestyle. If it were a reversed situation, how many Anglos would/could learn our languages, religions, medicine, mode of childrearing, education handed down or by self experience?
>
> Recognize that once your educational pursuit is completed, the Job Market is on a competitor basis. Again one has to adapt one's self to a foreign life style or mindset. There are other games to play in order to stay afloat in the job market. All of which is "trying to be anglo" because the rules of the game are anglo oriented and not Indian. Survival in the competitive world is to recognize role differentiations.
>
> Even if one should get a job with Indian Health Services or BIA, we service the Indian population but again by Anglo rules. But one has to recognize self and be committed to yourself, be your best friend for self gratification /praise. Others may not give it to you so give it to yourself. The self will not allow you to fail if you truly want, but others will so become self reliant."

Maxine Chuculate, Cherokee, a founding member of American Indian/Alaskan Native Nurses Association, instructs our aspiring nurses that:

> Study and diligence is necessary to attain goals. Really caring; sincere feeling for humanity; extending a helping hand to people in physical and emotional pain; coping with ones own problems; seeking and accepting supervision, willingness to make personal adjustment; attending seminars and workshops.

Assertiveness training and building a network of support services with other Alaskan Natives and American Indians is the agenda advocated by Grace Lincoln, Eskimo. Grace, a nurse, currently is employed as a social worker in the area of child protection service. She feels we need to support each other in our efforts in human services but also to increase our knowledge and share ideas via the neworks we build.

The accomplishments of the nurses in this chapter are an inspiration to our young people. These accomplishments are even more remarkable in light of facts like:

1. Always feel that you are as good as anyone else and capable of accomplishing your goals.

2. Don't be afraid to ask questions.

3. Try new ways of doing things ; if it doesn't work, try another way until until you find success.

4. Feel that being an Indian is your greatest asset.

5. Always remember that what you do as an individual will be reflected as an Indian as you are always a part of that society.

Josephine still lives in Isleta Pueblo. She is currently working on her Master's Degree in nursing while employed by U.S. Public Health Service, Indian Health Service as a Primary Consultant, Community Health Nursing for Albuquerque Area. She has a Master's degree in Public Administration in addition to the nursing degrees. She has a family with three of her four children in college and one daughter with a B.S. in Social Welfare. She stands as a person who took the best of several cultures and remained true to herself and her background.

Edith Ramsdell, Arapaho, also retained her tribal traditions. Her mother and grandmother were midwives for the reservation. She grew up with a deep interest in medicine, both traditional and modern. She dedicated her graduation from nurse's training to her mother who was deceased by that time. Her fine children gave her the encouragement to finish school. She states that despite sacrifice, "the day you graduate and look back, it was all worth it."

Ruth Backup's parents, Alaska Native, were afraid of her going to the "city" and worried because she had no money and such big dreams of becoming a nurse. She feels her Indian heritage helped her to be more sensitive and to pick up non-verbal cues more easily than her peers.

Jewel Slick, Sioux - Fort Peck, was considered a "novelty" when she attended nursing school in the 1950's. She was the only minority in a class of 203 students. Many "dumb" questions were directed to her. She encourages students to :

> Be perserverant and complete goals. Carry Indian heritage with pride and dignity. We are human beings of great talent and intelligence and let no one discourage you just because our skin is of color. Set high standards and principals and don't sway from them. Don't be a "Quitter".

Jewel currently is a Director of an American Indian Center in Des Moines, Iowa. She works hard as an advocate for American Indians and works on the Des Moines Human Rights Commission. She was named in WHO'S WHO OF AMERICAN WOMEN for 1983 - 84.

> In 1950, Indian women had completed a median of 7.4 years of schooling. Twenty years later the median was 10.5 years, slightly more than the 10.4 years for men. More than one third of both were high school graduates. However, only 10.1 percent of the women had completed one or more years of college.[19]

The older women in the group came through school at a time when only 5% of all employed Indian women held professional and technical jobs. This number had doubled by 1970 to 11%.

We need more Indian nurses to secure the 64% of the total Indian population in the United States that uses Indian Health Service as a primary health resource. The coments by the nurses that urge self-actualization by women aspiring to a nursing career were expanded on at a nursing conference by a panel of Indian health professionals at Fon du Lac Reservation, August 1984.

Arlene Wauakamau, R.N., Potawatomic, described self-actualization as being in harmony with one's self. A holistic approach to your being is necessary for you to be truly self-actualized. She suggested taking one day at a time and appreciating the gifts such as health, a beautiful day, or a family member who conquers a severe problem such as alcohol abuse.

Hattie Thunder Cloud Waker, B.S., R.N., Winnebago, stated that three tenths of 1% of the nurses in the nation are American Indian which brings us to about 1500 Indian nurses. She felt that the self actualized nurses were capable of delivering better care.

Kathy Annette, M.D., Red Lake Chippewa, felt that often times nurses could give a female physician the saving grace to get you through another day because they understood you as a woman. She and the other Indian woman physicians present praised the Indian nurses they had worked with. Most of these women had worked on self-actualization trying to adopt both cultures into a cohesive whole that would work for them.

The approximately 80 nurses at the conference discussed many pros and cons of nursing. Many had to do with bureaucratic rules of federal agencies which are not the subject at hand. Suffice it to state that they were lively, inspriring women and it would be good for young women aspiring to become nurses to attend such a conference.

[19]U.S. Department of Labor Women's Bureau - June 1977

Madonna Azure
and
Lori Garcia

Two female nursing students

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CHAPTER XI

PATHWAYS

Indian women have always been in demand. The Institute of Indian Studies from the Univeristy of South Dakota wrote about how important women were in the early days, because a warrior was not expected to do humble labor, not even to raise crops. Polygamy was customary in some tribes, because there was so much work to be done. Among the Sioux, the old grandmother was the autocrat of the lodge and held power and influence in her position.

Power and influence will be accorded to the Indian women in medical fields today by their tribes. We may not receive like treatment from the non-Indian world, but that should be dealt with more extensively in another book. The important point here is that young "medicine women" should seek the wisdom of the grandmothers if they wish to deserve the power and influence accorded them. Maturity is hard to come by. It is not just acquired through age. We are all embarrassed by childish acts of our past.

The exuberance of youth, however, lends well to the beginning of a difficult career. Debora Jone-Saumty, Kiowa-Cherokee-Seminole-Delaware, was a high school junior when she was involved in applied research in a neuropsycholgy laboratory. The patient contact, logic, and success of the scientific method appealed to her. She often found it difficult to assimilate contemporary social theories with those of her traditional upbringing. As an Indian woman, she was not expected to do well in graduate school. When she did, she was often penalized. She specialized in clinical psychology and will go on for her Ph.D. soon, with specialization in alcoholism and neuropsychology. She feels that dedication and perseverance are the keys to a health career.

F. Agnes Stroud-Lee, Ph.D., Pueblo, also developed her interest in science early. A seventh grade teacher made science very interesting for her. Agnes eventually specialized in atomic energy-radiation biology. She feels women should prepare as early as junior high school for science careers. She stresses the importance of good study and working habits and a positive attitude. She works as a consultant in the field of Radiation Biology and cytogentics, specializing in chromosome abnormalities due to radiation or birth defects. She retired from Los Alamos National Laboratory in 1979.

Retired speech and hearing therapist Mary L. Peake Buchanan, Cherokee and Menominee, was taught to be proud of her Indian heritage. She was born in Anadarko, Oklahoma territory in 1906. Her accomplishments are remarkable for the era when she

attended school. She took two years at Haskell Institute, Lawrence, Kansas. After passing a civil service exam, she completed the rest of her college work through summer school, extension courses, correspondence courses and night courses. It was over thirty years before she received her degree. She notes, "It wasn't easy."

She tells other students: "First there must be desire and interest. Women are capable of reaching any goal they have. Courage and strength are the two basic needs." She demonstrates this in the following summary:

> I started in the BIA in 1927 as a supervisor of student teachers at Haskell Institute, Lawrence, Kansas. From there I went to Hayward, Wisconsin, teaching the fourth grade. There I transferred to Fort Totten, North Dakota, teaching the first and second grades. Then I went to the Rosebud Reservation in South Dakota teaching in the reservation day schools. It was in these schools where I became aware of health needs of Indian children, especially ear infections, which not only caused hearing loss, but caused severe articulation problems. After Rosebud, I worked in two boarding schools in Oklahoma. Special education was just beginning at this time, so I began to take college courses to help me understand how I could help children with special needs. I then transferred to Sequoyoh School at Tahlequaah.At this time I completed my degree and set up a Speech and Hearing program (the first in BIA). Children were referred to this program from throughout Oklahoma; many cleft palate children, deaf children and children with articulation problems. I was then asked to join the faculty at Northeastern to teach and supervise clinical practice. I worked nine years at N.E. and have students in the field who are still in touch with me. I think special education is certainly a medically-related program and I would happily encourage young people to follow it, especially young women.
>
> After retiring from N.E., I worked as a consultant for four county health programs. This was for retired persons mainly, most of my cases were deaf, esophageal cases, or aphasia cases caused by strokes.

One recurrent theme from women we contacted was that a teacher or mentor they encountered early had encouraged them to go into a medical field. Haskell Institute, in Lawrence, Kansas, was the school most often mentioned. This year, 1985, is Haskell's centennial. The Indian world owes much to the teachers and administrators of that school, for developing so much talent from so many young Indians.

Other professions are dealing with problems similar to those we described for the field of medicine. American Indian Women are now in fields such as engineering, law and research.

In 1984, the American Indian Society of Science and Engineering had a conference which included a panel on women in engineering. This panel put forth some points that I think are good for all professional Indian women to think about :

(1) You should give other women encouragement. You can act as a mentor and provide opportunities for other women if you don't develop the "queen bee" syndrome.

(2) Work on your attitude constantly. Try to retain your humility, and don't come across as if you know it all. Ask for help, and then appreciate the help that you receive. People feel good when they give you help. Learn how to feel good asking for help without becoming a very dependant, helpless type person. There is a very fine line . We often have not learned how to walk it.

(3) Know where you are at, and dress accordingly to fit in the group. If you are expected to be in the latest fashion for a meeting with your employer, or a medical school admissions committee, dress as that group would expect you to dress. This is not a sign of weakness, but actually a sign of courtesy to the group that you are meeting with. If you are out on a field trip in a marsh, or inspecting an oil rig, be sure that you don't have on heels and hose. This not only is dangerous, but stupid. Jeans and sensible shoes should be worn at such sites.

(4) Become visible. Professionals in societies can allow you to meet people that will help you to help other Indian women. Becoming visible not only helps you but helps other people in your tribe. Try to develop a network among Indian women and other professionals so that you can advance to help others.

(5) Don't go into a job or medical school to prove something. If you go in paranoid, with a chip on your shoulder, you and all of those around you will suffer. Try to learn from the people you are with, and to establish yourself without sacrificing your own identity. Recognize when other people are threatened by you because you are different, (i.e., more or less educated, a minority, a women), but then understand this and don't retaliate by becoming threatened yourself. Exhibit professional quality in the work place and don't accept treatment as less than the professional you are. When you are in a culturally-traditional place, you should act as a woman in that particular culture and situation is expected to act. You should treat men the way that they expect to be treated in that particular environment. Find out the customs of tribes that you are with and act as women in that tribe act. Many Indian women who have difficulty surviving on their own reservations have reacted to snide remarks they would be better off ignoring. They then become more defensive, which brings on more remarks.

(6) Encourage family relationships among women you are around or supervise. If you can help other women to preserve their family lives, do so. If you believe in the axiom of "what goes around, comes around", you'll find other people trying to help you preserve your family supports.

Nancy Wallace, an industrial engineer that I had occasion to listen to at the American Indian Science and Engineering Society meeting in Los Angeles, 1984, gave a

short overview of her life. She talked about some of the problems that she had as an engineer, but gave some solutions of ways women can advance.

Ms. Wallace feels that some of the problems for women exist within their own minds. Many women have difficulty setting goals, consequently, they get pushed where they do not want to be pushed. She urges women to learn how to advance their own careers, and thereby control the range to their own destinies. To do this you must know where you want to advance. She also suggests that "making oneself visible and letting other people know you are out there" is necessary for advancement. She cautioned women no to let male collegues delegate them to positions where they answer phones, take notes and in other ways fulfill the expectations that men may have of women. Act like a professional! Dress like a professional! Expect to be treated as a professional by other professionals.

She was somewhat upset by the doublechecking on women, that doesn't seem to happen to men. I heard other women on the panel discuss this also. I have talked to women in medicine, Indians in medicine, and Indian women in medicine. The common theme is that some people almost hope you'll error, or make a poor judgement call, so that they can point out, "yes, they were right, you are not as good." It reinforced some of the observations to have Nancy Wallace mention this. She feels that the subtle types of discrimination against women, such as doublechecking on them, can hurt a career. Any mistake will be blown out of proportion, and you may not get the same chances at remediation that a non-minority or a male would get.

Twelve years ago, when the INMED Program started, we felt that the big problems would be getting students into medical school. We were also working on an engineering project at that time which barely got off the ground. The Albuquerque Law School was also starting to encourage Indian students to study law. Now, a decade later, we have graduated these early students into professional careers. The Indian women are finding the same discrimination that other women have found as they became professionals, with an added twist. We now must break down the very educated, sophisticated discrimination that exists in higher levels.

When I was growing up, I used to feel that I would prefer to be around a "redneck", because you always know where they are coming from, as opposed to "liberal", who likes you when it is politically expedient to do so. As I have grown older, I have found that some of the observations of my youth are correct. We all wish for, and should try to be, that very ethical person who does not bring about subtle discrimination, and is also self-confident enough to give everybody a fair shake. Unfortunately, some of the most prejudiced people I've run into recently have been some of our own students, who fight others over "who is the most Indian." They make it very difficult to improve relationships, so that the young ones behind us will have fair opportunities.

Nancy Wallace also talked about the mentorship that is so crucial for professional women to advance. She finds that the lack of women in top professional roles helps to mediate against mentorship. The "old boy's network" does exist and the situation where a woman must become one of the "old boy's" to get into the network is very difficult to deal with. A mentor could be one of many people.Mentoring includes

just having somebody to talk to and point out for you the things that you may not be seeing. Mentoring is an informal process. I have pondered on who my mentors have been over the years. Probably the strongest mentor that I have had over the last twelve years has been a man, John Vennes, Ph.D., Chairman of the Microbiology Department here at the University of North Dakota. I use to get mad at him during discussions,and I felt that arguing with him was like "punching at a cloud." Now I realize that my discussions with him are not really like "punching at a cloud", but were really him drowning out conclusions from me that I should have seen more easily. He teaches me in very subtle ways without making me feel picked on, forcing me to get my defenses up. This is a quality that many people do no have. I certainly do not possess it, and I don't hear many women (as they discuss mentoring) talk about the qualities that make a good mentor. A mentor is more than a friend, it is a person who can bring out the best in you. This reminds me of the old cliche we use to hang on our walls:

"A FRIEND"

is someone
who leaves you
with all your
freedom intact
but who obliges you
to be what
you are...
John L'Heureux

This is perhaps something that we as Indian women must think about when we start to talk about mentoring. The OHOYO Manual, mentioned previously, has a lot of discussion about mentoring, and some very positive ideas on how Indian women can help one another. I would recommend it to you. It can be obtained through the OHOYO Resource Center, 2301 Midwestern Parkway, Suite 214, Witchita Falls, TX 76308.

Nancy Wallace suggested that you should make every effort to meet as many people as you can. She noted that you really need contacts if you are going to get into a profession such as engineering. She talked about the serendipity that many of us have noted. "You do not just get jobs because you have the degrees." This is true even in medicine. It is more true that you do not get into medical, nursing, or some of the other professional schools without having someone around who knows how to approach a school, who knows what to say during the interview and how to fill out the forms. I remember the first time I applied for medical school. I did not know how the game was played. You must learn to trust other people and know other people in order to get the help you do need. Ms. Wallace also suggested that you should check a company before accepting a job, to see if there are many women at the top. If there are no women in top management, your chances of getting a top management job will also be decreased. This is also true in a hospital setting. There are hospitals, however, in which even the top nursing staff have very little to say, and the main decision makers are men. This should raise a red flag for any Indian woman in medicine who wishes to get a staff appointment at such a place.

An Indian woman must learn how to cope with being a "twofer". This is a double minority person who is used by companies to fill minority slots, so the companies will not have to hire additional minorities. There will be resentment towards you from minority men, as they will feel that you have deprived them of a slot because you are a double minority, regardless of your qualifications. Other minority women I have talked to,show some resentment about this situation, but more often they show saddness that it is occurring. I feel very sad that it occurs and we must do the best we can to leave the door open to Indian women who are now in training.

The current medical training system in the United States doesn't seem to value and support interpersonal relationships, which brings about a very isolating situation for both men and women. It is important to remember that in the 1920's, any man who got married during medical school could lose his scholarship. The idea was that "one is married to medicine" and a good medical student has no time for a wife.* There has been some progress during the last sixty years, but the idea of being married to medicine still remains in the minds of some of the medical students' preceptors. It is very difficult for a women in medicine, who already feels isolation. This is especially difficult if her husband is not in medicine and doesn't understand the social realities of the system under which she labors.

It has been documented that women medical doctors spend more time with their patients. This brings about a tension between competitive achievement orientation and patient care. Preceptors often interpret the extra time input as an inability to make decisons, or as an inability to come to a swift diagnosis. Some medical doctors associate itimacy with patients with a certain type of danger. Males in the United State society often fear intimacy, while the danger of isolation from other people is more accepted. The danger of isolation is sometimes converted into a feeling of helplessness, when one has no mentor to turn to during a time of need. One of the speakers at the AAMC meeting translated this feeling of helplessness into a reason for the omnipotent attitude that many physicians have. It's easier to pretend that you know it all, than to admit how lonely and helpless you feel. I have run into the same type of isolation as a minority person in a town with very few women in primary care. The town and your situation may contribute also to isolation, as medical school faculty are not always accepted on equal par with those in private practice, nor are government-employed doctors accepted on the same par. Many private practicioners feel that government doctors are stupid to accept the lower salaries, or that they are afraid to accept the responsibilities of private practice. One must not let such biases convince him/her that he/she is unworthy of being in medicine. Unfortunately, it can happen.

Women in medicine often discuss the difficulty in relating to their peer group from before medical school training and also a difficulty in relating to their new peers, a situation that is really serving to isolate them. Women in medicine, not just minority women, talk about being out-of-sync with both peer groups. I attended several discussions on this topic at the 1984 Association of American Medical Colleges Convention. It was correlated with the way immigrants might have felt when they came to the United States, and felt that they had difficulty in relating to the

*There were so few women in medicine, no one mentioned husbands.

people they left back home in the old country ; but they also had difficulty in relating to the first generation children born in America with the American values. The woman who goes to medical school can be disappointed and frustrated when she later tries to relate to women leading far different lives back home. The women may not be able to relate to her professional life ; and the medical woman may look with a twinge of jealousy at the others child rearing and secure family lifestyles.

Some people feel that women in medicine, as a defense mechanism, develop confidence in their work and relegate relationships with men and family to the back burner. This is a different situation than you would find with the male professional in the United States. Achievement for males enhances their desirability as a mate. Many women have to hide their achievements when they are on a date, as it may just frighten men. I know that when people ask me where I work, I will say "at the University" or "the hospital" or "for Indian Health Service" at which point the conclusion is that I'm a nurse, or a secretary ; and I usually don't alter that conclusion if I want to dance the rest of the evening. Eighty percent of women physicians marry professionals such as doctors, lawyers, finance people, etc. It is stated that some women doctors seek divorce due to financial independence, but another reason may be that there are few married role models in top positions in a women physician's world.

The women who can combine career and family successfully are few and far between, with all the demands and expectations that she should be a "wonder woman". It is also seductive and frightening to be a role model. Role models often have difficulty at admitting weaknesses or showing that they are under stress. I have been doing stress workshops about once every three months, during peak times of stress in my own life. By working with 20 - 30 other people on solving their stress problems, I find that I relieve my own anxieties better than I ever could have alone. This may be true partly because of a difficulty of getting into any other type of counseling, or asking for help. Studies have shown that it's very difficult to get women role models into psychological counseling, or to get them to ask for help when they need it. The pressure on achievement is always there and to ask for help can damage a women's chance for success. The people that you would ask to help you are usually the same people that have the power to determine your advancement if you are in a field like medicine. This may account for the high suicide rate ; when a women feels she cannot cope any longer.

There have been many discussions on the "chilly classroom". A study was done at the University of North Dakota in the winter of 1984, describing problems that women had encountered in the classroom. At the AAMC meeting in Chicago, similar conclusions were reached. Women in the classroom are much less likely to be called upon. When they are reciting, they are interrupted more often than men, and women are less often chosen as student assistant or put in charge of a group. Their names are less often remembered. This has been documented in numerous studies. Sexist humor and comments still occur. The quality remarks of women are often attributed to someone else, and women do not get credit for their good ideas. A woman panelist at the AAMC conference had been in medicine for many years, and had excellent credentials. She discussed her participation on a committee with ten men and two women. When the minutes of the committee came out, her remarks and ideas were attributed to the man who had spoken next in every incident.

Nobody can tell ya
There's only one song worth singing
They may try and sell ya
cause it hangs them up–
to see someone like you.
But you've gotta
Make your own kind of music
Sing your own special song,
Make your own kind of music
even if nobody else sings along.

Words & Music by Barry Mann
& Cynthia Wells
Copyright 1968 by Screen Gems
EMI Music Inc.
Hollywood, CA

These lyrics remind me of the first year of medical school. At the time I thought my isolation was because of my Indianness. A year later I found out we were all isolated from each other to a degree; and perhaps less at my medical school (Duluth, MN) than at other larger schools.

Later, I read such authors as Brown and Klein, who wrote:

"With admission into medical school, aspiring female physicians often encounter, many for the first time, a system whose basic tenets may force them into sometimes unresolvable identity crisis. Roeske and Lake speak of "the psychological conflict; the level of anxiety; the confusion about identity...the feeling of conflict appears to center around the issues of stereotypical, gender–defined roles and values.

How much deeper that conflict must be for those of us who have even different roles in extended family and values that don't emanate the medical profession. The conflict is evident in quotes from Indian medical and nursing students elsewhere in this book.

Pat Locke stated in 1973 that we would be sacrificing our young people if we pushed them into careers as physicians.

Pat Locke, Sioux educator and administrator, was not enthused at the prospect of Indians becoming physicians. She said it was too much of a "sacrifice". It was bad enough they had to learn law and engineering, but that was necessary. Indians knew the special relationship to Mother Earth that had to be protected by lawyers and engineers. Physicians could come from the outside world.

The words were more true than I ever dreamed when I first heard them. To hold a baby that will not live in your arms, to ache with the mourning parents, that is a sacrifice. It is balanced somewhat seeing a child you delivered run and play. Pat was perhaps thinking more about the socialization process of medical school.

Ten years later I start to see what she really understood long before I could. Brown and Klein talk about the covert prejudices against the female physician that encourages her to adopt the bias of the male peer group. Not all the male physicians have prejudices against either women or minorities. I thank God for Dr. Simson and the other surgeons at St. Louis Park Medical Center, who gave me the confidence and the will to grow and fight back when I started my clinical years.

Unfortunately, women physicians have no way of seeing quickly who is a friend.[20] We often do not understand our own misery enough to seek help, or to give help. Brown and Klein note that the usual help, when it is given, focuses on problems that are traditionally defined as areas of conflict for women – "family versus career," "feminine versus masculine" qualities, and the like. They felt that issues of how authority is conferred upon, internalized and excercised by women in medicine are issues that have not been addressed. At the University of Minnesota-Duluth School of Medicine, we read The Social Constitution of Reality[21] by Berger, to help us understand the system. That assignment helped me in ways Denny Brissett, class instructor, probably never realized. Those in power decided what is real for those of us not in power. On pages 108 and 109 of the Anchor edition, Berger writes...

> "The alternative universe presented by the other society must be met with the best possible reasons for the superiority of one's own...
>
> The historical outcome of each clash of gods was determined by those who wielded the better weapons rather than those who had the better arguments.

It is interesting that the index of this book lists: Minority groups: See Deviance, Women, (See also Sexality) mothers (See Children, Significant others).

The book taught me a lot! I recommend it for minority women in a man's occupation, to be read from your vantage point of life.

[20]Young, Jeffery "Doctored Evidence", San Francisco, August, 1983. An interesting account of a Black woman surgeon, Ramona Tascol, M.D., who won her case in court against racial and sexual discrimination but found that residency doors were closed after that, for various reasons.

[21]Berger, P.L., Luckmann, T., The Social Construction of Reality, Doubleday & Co., Inc., 1966.

For me the tragedy seems to be that I've changed somehow. The reality that the medical society has constructed for us holds a lot of power. This power includes staff privileges, state licenses, and the network to survive the daily bombardment of other peoples' ills and problems. It is hard to "sing your own kind of song" and continue practicing medicine. The isolated physician soon becomes outdated and burned out.

More Tips for Success, from me and others

1. Do one thing at a time and do it completely, and then leave it completely for the next task.

2. Know your limits--when you cannot think clearly--ask for help, do not be a martyr.

3. Chances are you won't be as great a threat to Indian men as you will be to non-Indian men. Use this to see if your assertiveness, so necessary in medicine, has become overbearing and unproductive.

4. Older women have a better chance with medical school admissions committees. Any women who has applied three times and not gotten in to medical school should probably find another career.

5. Work hard--the difference between the successful and unsuccessful Indian medical students, in my observation, is amount of compulsive work--not necessarily the amount of intellect.

6. Understand your capacity for stress--know when you have exceeded your safe limit--find ways of relieving stress.

7. Read, anything and everything. Decide on goals, learn about yourself by trying to expose yourself to as many new experiences and endeavors as possible (Constance E.R. Deer, Oregon, Wisconsin)

8. Dedication and perseverance are the keys to a health career. The helping professions can be very trying and discouraging, but the rewards far surpass the trouble. (Deborah J. Hones -Saumty, Okmulgee, OK)

9. A women (girl) should begin to prepare herself as early as junior high school. Good study and working habits are essential, and also putting priorities first. A positive attitude and determination are necessary too. (F. Agnes Stroud -- Lee, Ph.D., Belen, NM)

10. I would urge any woman to get her Bachelor of Science degree in Nursing, as the trend is going that way, in order to advance in her field. Nursing is becoming more and more specialized.

Preparing for a health career will require dedication and hard work, achieving a worthwhile goal in life usually does. I am thankful for the opportunity to practice medicine, and I'm also thankful for people like Dr. Jim Boulger, Dean of Student Affairs at Duluth, who kept me going when I was discouraged. I also thank my daughters and my family for their support. It has been worth it.

MEDICINE WOMEN

2

OUR TREASURED MOMENTS

BEST COPY AVAILABLE

UNSUNG HEROES

Wife, mother, single parent, working mother, working wife - these are some of the roles a woman assumes to assist those who depend on her. In fulfilling each of these roles, a woman is motivated by a concern for others.

While she is a health career student, a woman offers sincere interest and support to her fellow students ;so that each may achieve a degree in medicine or a related health field Those of us associated with the INMED Program recognize the efforts of our students, students who are motivated toward a career of easing the pain and suffering of others.

Each woman needs support during her education. It is up to us - as parents, brothers, sisters, aunts, uncles, cousins, grandparents, husbands, or boyfriends - to encourage and assist our students. We must share the burdens they bear in balancing study with home chores, child care and other family demands. We will all be rewarded for our efforts.

The Advisory Board supports you, and may you be guided by the Great Spirit in fulfilling your roles.

Jim Claymore, Chairman
INMED Advisory Board

Mr. Claymore has been an important supporter of INMED throughout the program's history. Mr. Claymore was Bureau of Indian Affairs superintendant at the Cheyenne River Reservation in South Dakota. He retired from BIA ten years ago, and has since invested extensive time providing guidance and support for INMED ; as well as discussing the program's accomplishments with students, teachers, tribal councils and legislators.